Mozambique

Country Operational Plan

COP 2020

Strategic Direction Summary

March 16, 2020

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1.0 Goal Statement

Despite Mozambique's substantial increases in the number of people who test positive for the human immunodeficiency virus (HIV) and the number of people living with HIV (PLHIV) currently on anti-retroviral treatment (ART), the inability to retain new clients on treatment has jeopardized country goals for achieving epidemic control, placing United States Government (USG) investments at risk. A program 'reboot' in COP19 was needed to draw an immediate focus on retention and address this severe and chronic issue, while at the same time creating greater efficiencies in our program through better partner management and greater investment in high performing approaches and populations with greatest gaps.

Asymptomatic young men who are not on treatment drive the epidemic in Mozambique and are responsible for 66% of new HIV infections to young women 15-24 years of age. The 2020 Country Operational Plan (COP20) will focus on specific populations with the largest gaps in diagnosis, linkage and retention, with a primary focus on adolescent and young girls and men, ages 15-24 and 19-29 respectively. Intensive case management models that partner young men and women with peer and community support will help ensure linkage to treatment, retention and viral load suppression. The President's Emergency Plan for AIDS Relief (PEPFAR) Mozambique data demonstrates that men are much more likely to drop out of treatment, with a higher proportion having dropped out for longer than six months, requiring new approaches to find them and bring them back to treatment. A new approach using a private sector marketing model will characterize the reasons why men drop out and develop tailored messages that speak to their needs for treatment. COP20 will also focus resources on geographical areas where vertical transmission rates from mother to child are high, namely in Nampula, Zambezia and Cabo Delgado. PEPFAR Mozambique gained efficiencies in testing from the COP19 reboot and in COP20 will now implement more efficient models of index testing and provider-initiated testing, building on impressive yields achieved in COP19.

PEPFAR Mozambique will further refine and focus its prevention program to stop voluntary medical male circumcision (VMMC) in boys 10-14 to concentrate on offering services to young men 15 and older. PEPFAR Mozambique will expand key populations programming through KPIF resources, ensuring KP-friendly services that are offered in a respectful manner and meet the needs of these communities. Orphaned/Vulnerable Children (OVC) programming will be extended to CLHIV, providing important education, nutrition and psychological support services that ensure that children and adolescents stay on treatment. Finally, holistic prevention programs for young girls through the DREAMS program will be expanded from 9 to 32 districts, offering greater opportunities to girls in high incidence and high prevalence areas to be empowered to prevent contracting HIV, and provide better services if they are positive.

COP 20 will implement a revamped service delivery package led by the GRM, which includes six-month drug prescription and greater and more cost-efficient patient centered service delivery models that will enable PEPFAR Mozambique to stay on pace with its ambitious treatment and viral suppression targets within a prioritized subset of 628 facilities that account for 90 percent of

PLHIV. Furthermore, the expansion of Dolutegravir across all populations by the end of COP 19 will be a critical factor in enhancing retention and achieving viral load suppression. With sufficient in-country of optimized pediatric regimens expected by May 2020, pediatric treatment outcomes will also improve. Provision of preexposure prophylaxis (PrEP) will be expanded to all provinces with an extension of PrEP to adolescent girls above 15 years old, as well as to high risk groups, sero-discordant couples, key populations, PBLW and high-risk adolescent girls and boys.

COP20 will build on recent gains made in viral suppression by maintaining fidelity to national guidelines on viral load (VL) testing, concentrated psycho-social and literacy support for patients who need it, and timely transfer of clients with treatment failure to second/third line regimens. The results of a lab optimization analysis will identify opportunities to shift laboratory and diagnostic capability across the network ensuring the most efficient use of different platforms and setting for testing that coupled with DISA-link improvements can deliver results to clinicians and patients to better monitor treatment outcomes. Site level improvements to ensure that viral load results are recorded in patient charts and subsequent provider counseling on treatment results will improve viral load suppression across all age bands. Additive improvements to the patient data management system using Open -MRS will be supported so that Provinces and Districts can better use the data and trouble-shoot site performance and so that clinicians are better able to follow up and return patients to care. Data interoperability will be addressed between pharmacy, clinic, laboratory and community so that patient care can be proactively managed, and patients virally suppressed. Management improvement will be addressed jointly with the Ministry of Health (MISAU) in order to improve patient flow, human resources for health (HRH) further optimization, extended hours (either through shift work or shifted hours) and other differentiated service delivery (DSD) models that benefit specific patient subpopulations.

The PEPFAR Mozambique platform called Analyzing Joint Underperformance and Determining Assistance (AJUDA) – the Portuguese word for help – demonstrates that long-term retention can be achieved through a more rigorous and tailored monitoring approach, and a tailored response to the barriers clients face at facilities and in the community. Since AJUDA began, the adjusted one-month retention rate of 63 percent in September 2018 increased to 86 percent by April 2019 among the 127-high volume, low retention facilities accounting for 50 percent of all PLHIV. A more substantive accountability and action framework agreed to by PEPFAR Mozambique, the Government of the Republic of Mozambique (GRM) and PEPFAR-funded partners has shown signs of improving critical aspects of HIV care and treatment and addressing barriers identified by defaulters as limiting their willingness to remain in treatment. AJUDA combined with client centered treatment models such as mobile brigades, extended clinic hours, special human resource cadres that meet the needs of specific target groups, and higher quality site and community-level counseling and treatment services will ensure improved retention on treatment.

Additional cost-saving measures in COP20 include controlling partner funds distribution for more effective outlay management, outsourcing last-mile logistics to specialists, and continued transition of program responsibilities to GRM institutions in line with PEPFAR Mozambique sustainability

objectives. An innovative outsourcing of transport of laboratory specimens to the private sector will further contribute to lower costs and greater reliability within the lab network.

Finally this COP marks unprecedented contributions of civil society, multilateral agencies, and the GRM, who work in concert with PEPFAR Mozambique to identify novel community-oriented programming designed to hold facilities and clinical partners more accountable for quality HIV services, while improving patient literacy and strengthening local platforms to encourage treatment follow-up from within traditional networks. Close coordination with the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) and the GRM in the development of the 2020-2023 Global Fund grant proposals will ensure the most optimal use of USG and Global Fund resources. Global Fund and PEPFAR Mozambique are collaborating closely on identification of districts where the DREAMS program will be implemented, as well as, hand in glove coordination of drug and commodity procurement. In order to move the dialog on HIV from a health care centered framework, we also aim to use COP20 funds to embark on a campaign to reduce stigma and discrimination and focus on positive messaging about HIV such as U=U building on our treatment literacy work, but in a more aggressive and visible way, though involvement of the Government of Mozambique at its highest levels to mobilize agents of change and promote a well-orchestrated trickle down of information that will have an impact of treatment, retention and viral suppression.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Mozambique has a population of approximately 32.5 million people with 12.7 million (43.6%) under 15 years of age. The national Indicators of Immunization, Malaria and HIV/AIDS survey (IMASIDA) in 2015 estimated HIV prevalence at 13.2 percent, with substantial variation in provincial prevalence that ranged from 5.2 percent in Tete Province to 24.4 percent in Gaza Province (2015, IMASIDA)[1]. IMASIDA data indicate that Mozambique is still challenged by a generalized HIV epidemic. As of 2020, 2.3 million people are estimated to be living with HIV (PLHIV) in Mozambique, with a higher prevalence among women, 15.1 percent versus 10.2 percent among men (2019, Spectrum v5.84). HIV prevalence among adolescent girls (ages 15-19) is estimated at 6.5 percent, and among young women (ages 20-24) prevalence is estimated at 13.3 percent, compared to 1.5 percent and 5.3 percent among adolescent boys and young men, respectively. A population-based HIV impact assessment (PHIA) is underway (preliminary results expected by December 2020).

As of Q1 FY2020, 1.34M or approximately 53 percent of all PLHIV were estimated to be on antiretroviral therapy (ART). While Mozambique has made progress toward the Joint United Nations Programme on HIV and AIDS (UNAIDS) 95-95-95 goal with 75% of PLHIV aware of their status, 72% of those who know their status are on ART, and 81% viral suppression among those

[1] "INE Destaques — Instituto Nacional de Estatistica." http://www.ine.gov.mz/. Accessed 8 May. 2019

with a viral load (VL) test, major gaps remain among adolescent boys and adult men (15 -49) at 49-27-74, respectively.

Estimates suggest Mozambique will have 129,044 new HIV infections where 26.4%, or 34,053 of new HIV infections are among adolescent girls and young women (AGYW; ages 15-24 years) compared to 13.3%, or 17,223 among men in the same age group (Table 2.1.1.1).

The HIV epidemic has contributed to reduced life expectancy in 2018 at 59.3 overall but up slightly from 2016 when estimated at 58 years for men and 62 years for women in 2016 by the World Health Organization (WHO).[2] An estimated 920,000 children have been orphaned by AIDS.[3] Despite encouraging economic growth in 2015 (6.6 percent), Mozambique's economy suffered a major blow following a report of nearly $2 billion in government-backed hidden debt. This report contributed to rapid inflation and a reduced gross domestic product (GDP), falling from $16.9 billion in 2014 to $11.0 billion in 2016, recovering in 2018 to $14.7 billion.[5] In 2015, the Human Development Index ranked Mozambique 180 out of 187 countries.[46] The World Bank estimated 60 percent of Mozambicans in 2014 lived on less than $1.25 per day, with the gross national income (GNI) per capita falling from $620 in 2014 to $460 in 2018.[57] Seventy percent of Mozambicans are estimated to be poor and 37 percent destitute, with substantial variation by region and province.[6]

In addition to existing economic challenges, two significant cyclones hit Mozambique in March and April of 2019, producing torrential rains and strong winds across wide swaths of the country. Cyclone Idai, the first of the two cyclones, is now considered the worst natural disaster in southern Africa in nearly two decades. The catastrophic flooding triggered by the storm killed more than 600 people and nearly 1.9 million became in need of assistance. In Sofala, the most affected province, more than 90 percent of health centers were damaged or destroyed. Over 240,000 houses and 1.7 million acres of crops were damaged or destroyed, increasing food insecurity over subsequent months and forcing many households to resettle on pieces of land with no existing infrastructure. Cyclone Kenneth was also extremely destructive, displacing over 21,000 people and causing over 40 deaths. Over 34,000 houses were damaged or destroyed and 200,000 people became in need of assistance.

Despite ongoing challenges, several key health indicators have improved over time. Antenatal care (ANC) coverage, defined as at least one ANC clinic visit, increased to 93 percent, with 70 percent of women delivering in a health facility.[7] Under-five child mortality was 90/1,000 live births,

[2] "WHO | Mozambique - World Health Organization." https://www.who.int/countries/moz/en/. Accessed 8 May. 2019.

[3] "Mozambique | UNAIDS." http://www.unaids.org/en/regionscountries/countries/mozambique. Accessed 8 May. 2019.

[4] Human Development Report, 2015, UNDP

[5] World Bank, 2014-2016 https://data.worldbank.org/country/mozambique

[6] Oxford Poverty and Human Development Initiative (2016). "Mozambique Country Briefing", Multidimensional Poverty Index Data Bank. OPHI, University of Oxford. Available at: www.ophi.org.uk/multidimensional-poverty-index/mpi-country-briefings/

[7] IMASIDA, 2015.

declining from 103/1,000 live births in 2010.[8] Malaria, acute respiratory infections, and vaccine-preventable diseases are the main causes of child mortality, with malaria contributing to one-third of deaths. Forty-three percent of children-under-the-age of five years are stunted.

The Gender Inequality Index synthesizes gender-based inequalities in three dimensions—reproductive health, empowerment, and economic activity—on which Mozambique ranked 138 of 155 countries in 2017.[9] Mozambique has high rates of early marriage; 60 percent of women (ages 25-49) were married before the age of 20, and 40 percent of Mozambican women become pregnant before the age of 20. The adolescent pregnancy rate is 137.8 births per 1,000 live births and the risk of death among pregnant teenagers is four times higher than for women above the age of 20. Only 1.5 percent of adult women have reached at least a secondary-school education level compared to six percent of adult men.[10]

Similar to other African countries, Mozambique is experiencing a substantial increase in the proportion of Mozambicans who are adolescents or young adults. As of the 2017 census, 12.5 million (approximately 46.6 percent) of the country's population is less than 15 years of age.[11] As these youth become sexually active, without comprehensive measures taken now that reduce the pool of HIV positive persons who are not on ART and virally suppressed, the opportunity to achieve epidemic control by 2020 will be lost. PEPFAR and GRM are acutely aware of this emerging challenge and are taking all actions with a sense of urgency.

A Modes of Transmission Model conducted in 2013 shows that 29 percent of new infections were among sex workers, their clients, and men who have sex with men (MSM). Additionally, the model estimated that 26 percent of new infections occur among people in stable sexual relationships, due in large part to high rates of serodiscordance and low rates of condom use among couples. Individuals in multiple concurrent partnerships contributed to 23 percent of new adult infections. Mobile and migrant workers such as miners, agricultural workers, prison populations, the military, and truck drivers also constitute priority populations.[12]

Mozambique is challenged by a low national rate of retention in care and adherence to ART. The 12-month retention among PLHIV newly initiating ART in 2018 was 68 percent overall, including 67 percent among pregnant woman, 70 percent among children under 15 years old, and 68 percent among adults. PEPFAR Mozambique is aggressively implementing countermeasures and testing innovations at the facility and community level to retain and track PLHIV on treatment (see Section 2.2 below).

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[8] Mozambique DHS, 2011 & UNICEF, 2012.

[9] "Gender Inequality Index - | Human Development Reports - UNDP." http://hdr.undp.org/en/composite/GII. Accessed 8 May. 2019.

[10] Human Development Report 2014, UNDP.

[11] "Censo 2017 Brochura dos Resultados Definitivos do IV RGPH ..." http://www.ine.gov.mz/iv-rgph-2017/mocambique/censo-2017-brochura-dos-resultados-definitivos-do-iv-rgph-nacional.pdf/view. Accessed 8 May. 2019.

[12] Military – Seroprevalence and Behavioral Epidemiology Risk Survey in the Armed Forces of Mozambique 2010.

The health system contends with substantial challenges that include stagnant domestic resource mobilization, insufficient infrastructure, and a critical shortage of human resources. In 2014, a study estimated that 90 percent of Mozambicans live in a primary health care area defined as over a one hour walk from a primary health care center.[13] Overall, the ratio of population per hospital bed is one bed per 1,038 persons, with substantial variation across the country.[14] HRH are severely constrained with 7.8 doctors, 26.8 nurses, and a total of 100.2 health care workers (HCW) per 100,000 people.[15] Together with uneven geographic distribution and limited supervision, there are an inadequate number of trained HCW in all cadres.

GRM is responsible for HIV/AIDS-related service delivery, along with the development, implementation and oversight of policies and regulations. GRM information systems and monitoring and evaluation (M&E) efforts, heavily supported by external funding, are challenged by fragmented components and system patches that do not provide timely and accurate health data. PEPFAR augments GRM supply chain and commodities management to keep pace with growing ART and commodity needs. The laboratory network for HIV care and treatment also requires significant investment to expand diagnostic capacity; at present only 400 (27.8 percent) of 1,438 health units have laboratories.

Despite these challenges, progress in the number of people on ART has been remarkable, with threefold increases following the 2011 launch of MISAU's national *HIV and AIDS Response – Strategic Acceleration Plan for Mozambique 2013-2017* and the 2016 introduction of *Test and Start*. The number of health facilities offering ART increased from 255 in 2011 to 1,530 by 2020.[16] Based on data from MISAU and PEPFAR Mozambique, approximately 1.34M persons were estimated to be on ART after Q1 FY2020.

[13] Luis & Cabral, Geographic accessibility to primary healthcare centers in Mozambique, 2016.
[14] MOH – DRH. Relatório Anual dos Recursos Humanos. Maputo, Abril 2014.
[15] MOH/MISAU, 2016. WHO (2006) estimates 230 medical professionals per 100,000 people as a minimum threshold necessary to provide essential health interventions.
[16] Mozambique FY20, Q1 MER

Table 2.1.1: Host Country Government Results															
	Total Population Size Estimate		**<15**				**15-24**				**25+**				**Source, Year**
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	32,548,837		7,227,538	22%	7,302,640	22%	3,345,983	10%	3,367,771	10%	6,006,664	18%	5,298,241	16%	NAOMI estimates 2020
HIV Prevalence (%)		7.1%		1.1%*		1.2%*		6.5%		2.8%		18.3%		14.3%	NAOMI estimates 2020
AIDS Deaths (per year)	47,645		3,537		3,634		2,762		1,788		15,566		20,358		Spectrum v5.84, 2020
# PLHIV	2,307,842		69,719		72,249		218,229		94,710		1,098,147		754,788		NAOMI estimates 2020
Incidence Rate (infections/1000 person-years)		4.27						10.89		5.26		6.41		7.32	Spectrum v5.84, 2020
New Infections (2020)	129,044		6,434		6,617		34,053		17,223		31,468		33,249		Spectrum v5.84, 2020
Annual births (2019)	1,113,057														Ministry of Health, SISMA 2019
% of Pregnant Women with at least one ANC visit		93%													IMASIDA (AIS) 2015
Pregnant women needing ARVs (2020)	103,080														Spectrum v5.84, 2020
Orphans (Total-maternal, paternal, double) (2020)	2,168,883														Spectrum v5.84, 2020

Notified TB cases (2019)	85,450														PEFPAR data from DATIM, 2019
% of TB cases that are HIV infected (2019)	32.22%														PEFPAR data from DATIM, 2019
% of Males Circumcised (2019)		62.3%				65%*				70.4%				59.6%	DMPPT 2.0, 2020
Estimated Population Size of MSM	41,393														Key Population Size Estimation informed by data collected through 2017
MSM HIV Prevalence	2,800	7%													Key Population Size Estimation informed by data collected through 2017
Estimated Population Size of FSW	93,412														Key Population Size Estimation informed by data collected through 2017
FSW HIV Prevalence	21,631	23.2%													Key Population Size

															Estimation informed by data collected through 2017
Estimated Population Size of PWID	13,514														Key Population Size Estimation informed by data collected through 2017
PWID HIV Prevalence	5,193	38%													Key Population Size Estimation informed by data collected through 2017
PWID HIV Prevalence		24%													Key Population Size Estimation informed by data collected through 2017

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate 2020 (DemProj v7.584 & Naomi)	HIV Prevalence 2020 (DemProj v7.584 & Naomi)	Estimated Total PLHIV 2020 (Spectrum v7.584 & Naomi)	PLHIV diagnosed (Spectrum v7.584 & Shiny 90)	On ART (TX_CURR MER FY20 Q1)	ART Coverage (MER FY20 Q1/2020 PLHIV)	Viral Suppression (MER FY20 Q1)	Tested for HIV (HTS_TST FY19 Q2-FY20 Q1)	Diagnosed HIV Positive (HTS_POS FY19 Q2-FY20 Q1)	Initiated on ART (New on ART FY19 Q2-FY20 Q1)
	(#)	(%)	(#)	(%)	(#)	(%)	(%)	(#)	(#)	(#)
Total population	32,548,837	7.1%	2,307,842	75%	1,230,687	53%	81%	7,693,212	338,061	279,088
Population <15 years	14,530,178	1.0%	141,968	54%	76,596	54%	51%	1,257,493	19674	18,167
Men 15-24 years	3,367,771	2.8%	94,710	43%	23,172	24%	67%	904,338	19369	12,201
Men 25+ years	5,298,241	14.2%	754,788	67%	319,325	42%	82%	1,241,634	111314	84,390
Women 15-24 years	3,345,983	6.5%	218,229	70%	122,766	56%	78%	2,078,972	61049	53,413
Women 25+ years	6,006,664	18.3%	1,098,147	86%	688,828	63%	85%	2,210,775	126655	110,916
MSM*	41,393	6.76%	2,800	8.8%	N/A	3.5%	N/A	N/A	N/A	N/A
FSW	93,523	23.40%	21,866	22.3%	N/A	12.6%	N/A	N/A	N/A	N/A
PWID	13,514	38.40%	5,193	62.3%	N/A	42.2%	N/A	N/A	N/A	N/A
Priority Pop Prisoners	N/A	24%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

* Key pops size estimation analysis

** IBBS MSM and FSW 2011, PID 2014

Figure 2.1.3: National and PEPFR Trend for Individuals currently on Treatment

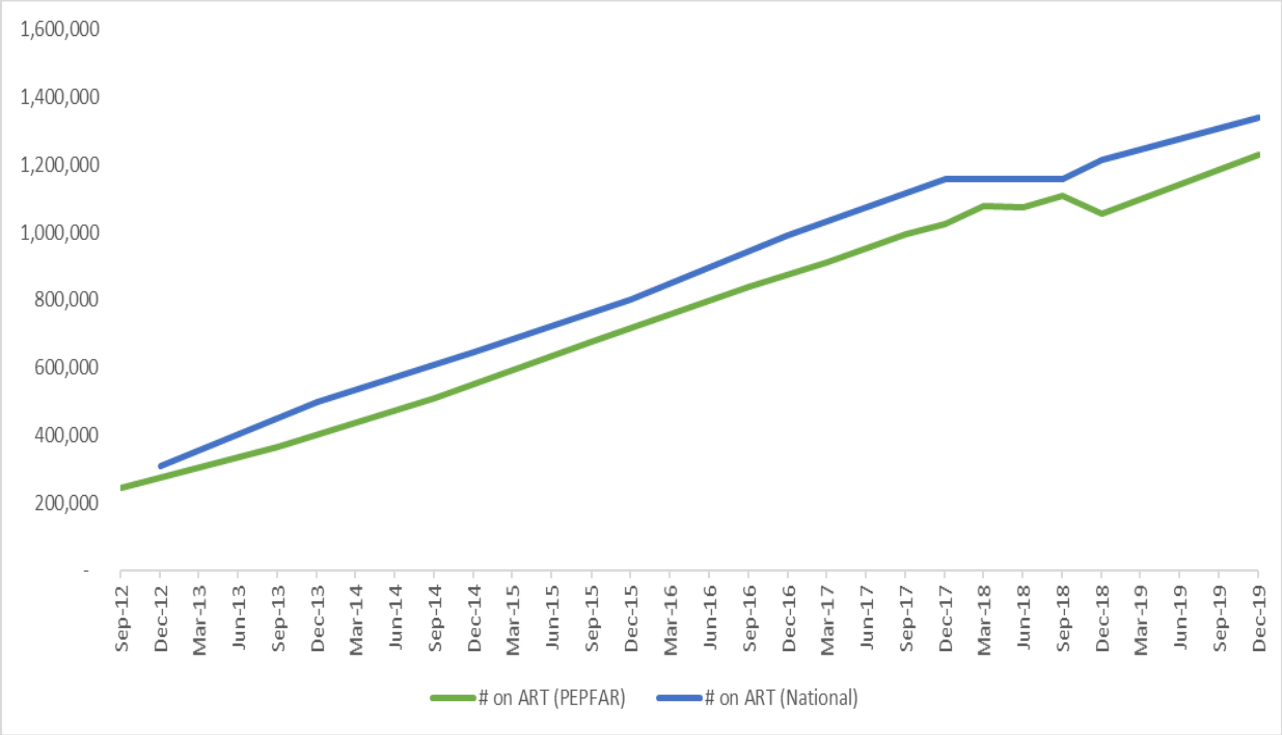


Figure 2.1.4: Updated Trend of New Trend for Individuals currently on Treatment Infections and All-Cause Mortality Among PLHIV

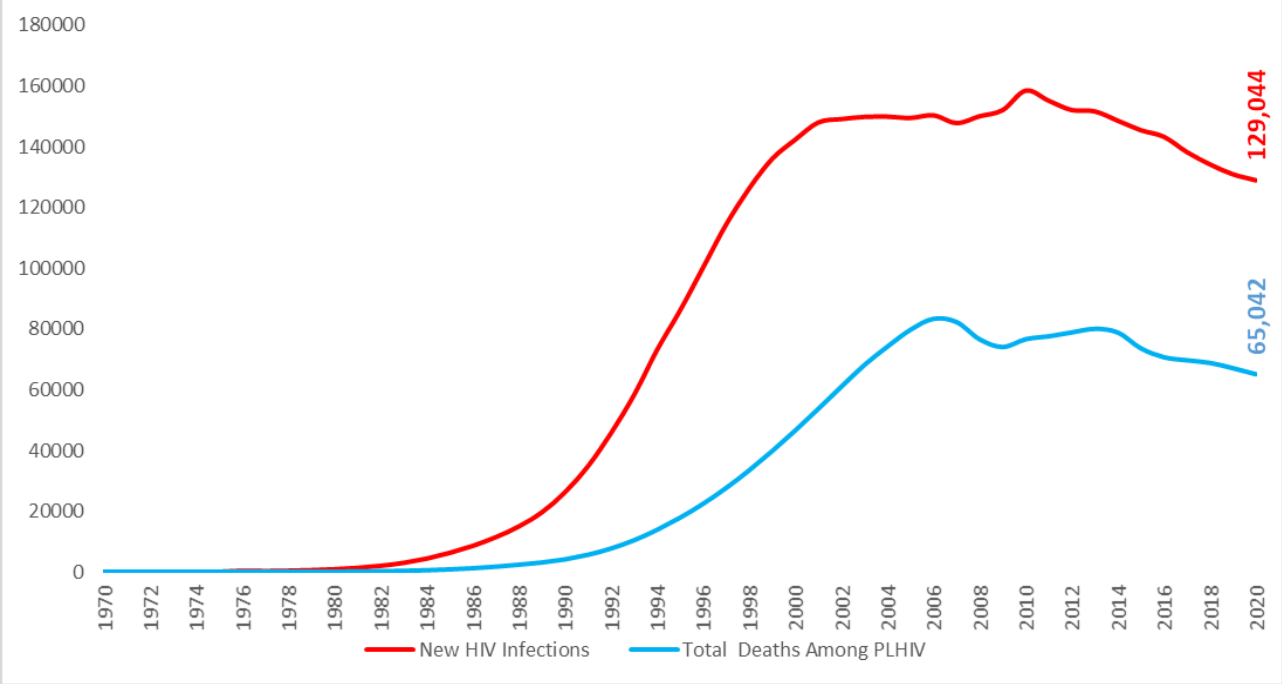


Figure 2.1.5: Progress on retaining individuals from FY19Q1 to FY20 Q1

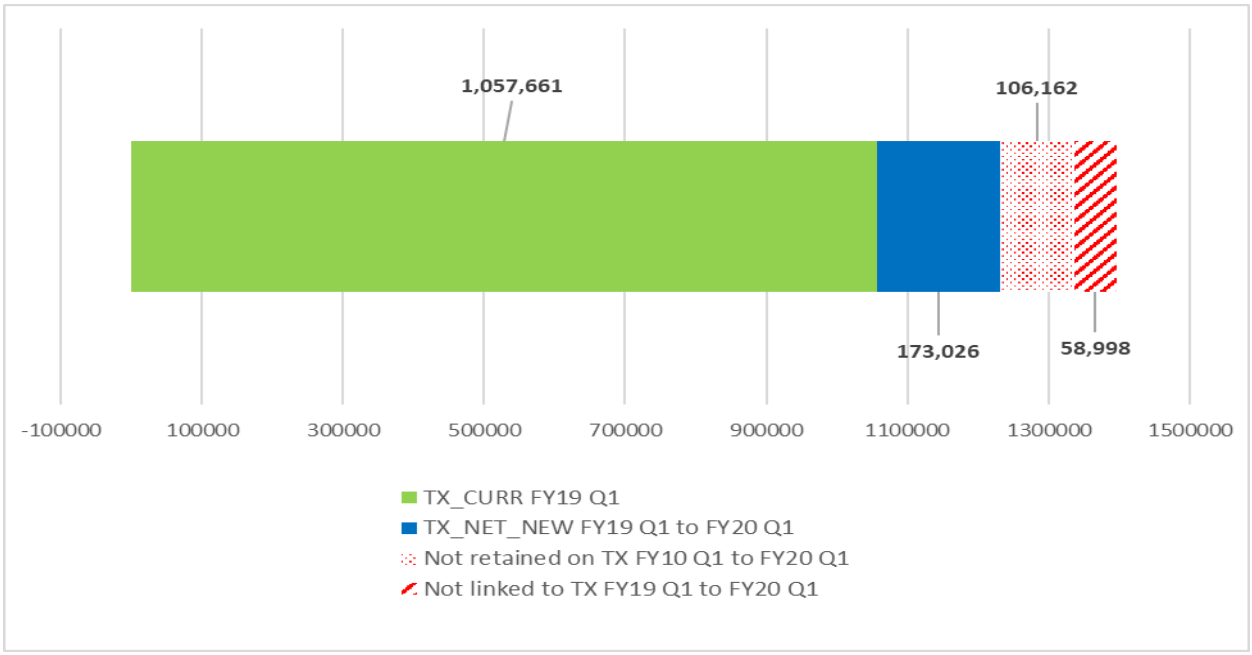


Figure 2.1.6: Proportion of clients lost in life-long ART in FY19 from ART 2018 Q4 to 2019 Q4

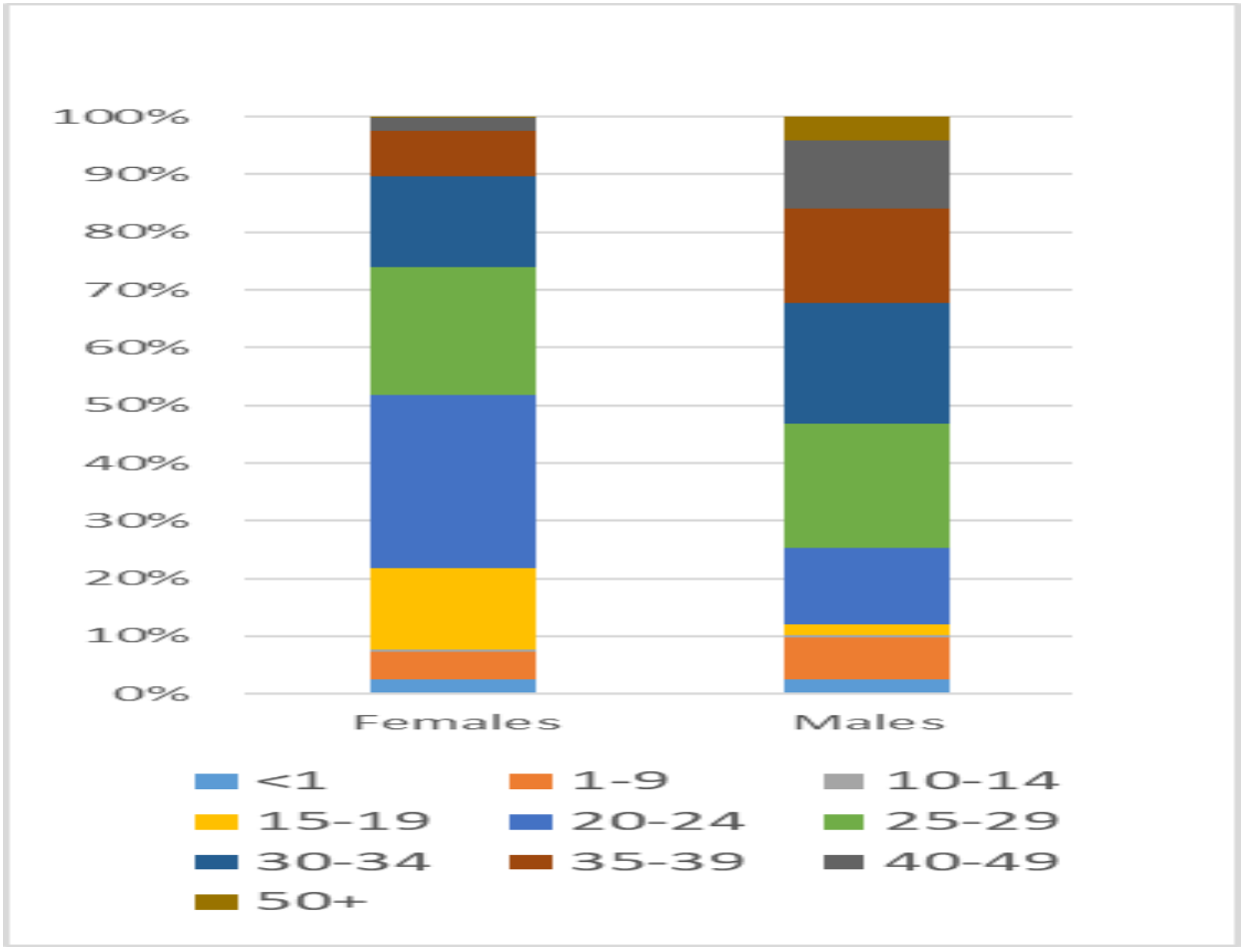


Figure 2.1.7: Epidemiologic Trends and Program Response for Mozambique

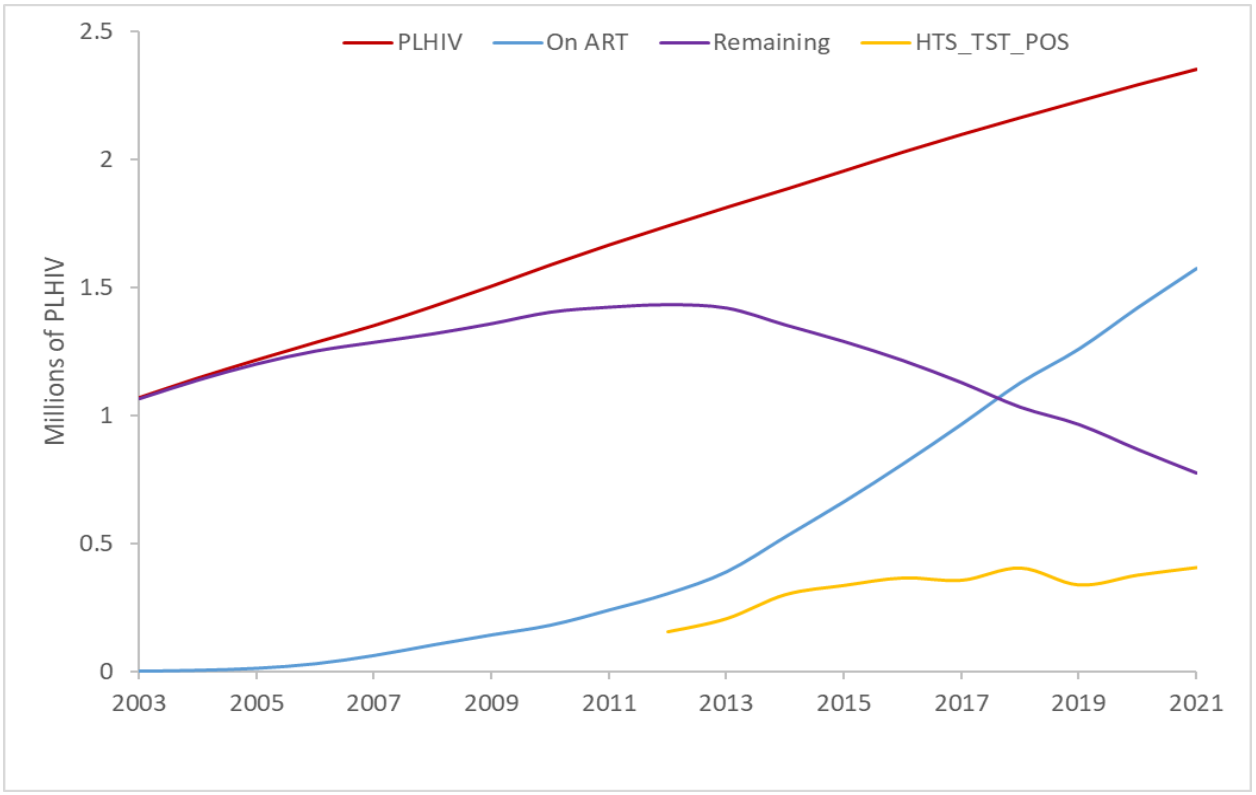
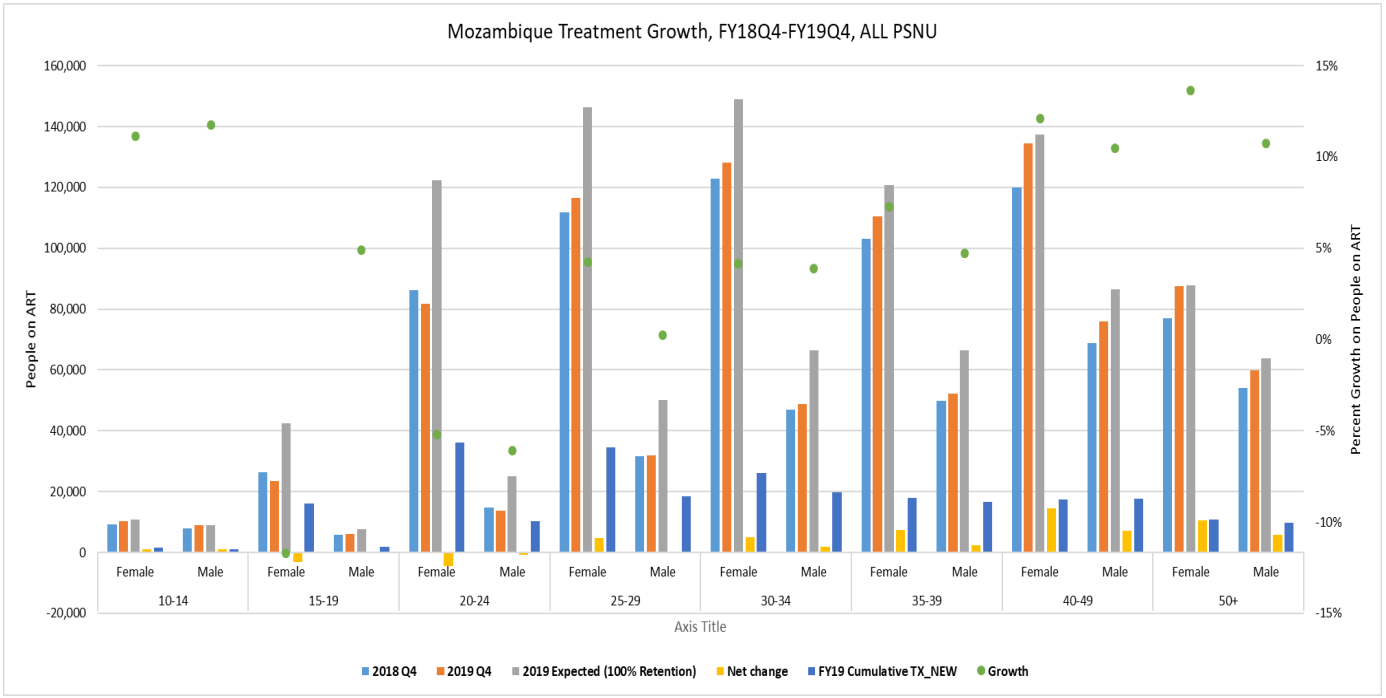


Figure 2.1.8: Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4



2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention

During COP20, PEPFAR Mozambique will work with GRM to improve retention among all persons receiving HIV care**.** Overall 12-month retention in COP 19 was 67%, with variations by subpopulations and geographic designations. In order to address challenges and program gaps identified, PEPFAR Mozambique, in coordination with GRM, will support implementation of new activities and interventions during COP20.

Advanced disease

In Mozambique the proportion of patients with advanced disease varies from 20% in Manica to 28% in Maputo Cidade (Table 2.2.1). Though decreasing in prevalence, low CD4 at ART initiation remains a problem that should be urgently addressed. During COP19, PEPFAR Mozambique is providing technical support to GRM in order to develop advanced disease guidelines and provider job aids. PEPFAR Mozambique, through implementing partner cooperative agreements, has also facilitated initial trainings at the level of the central government.

The advanced disease diagnostic and therapeutic package is composed of (i) CD4 screening and referral, (ii) co-trimoxazole prophylaxis, (iii) screening for active tuberculosis (TB) with LAM and Xpert MTB/RIF Ultra, and (iv) screening for cryptococcal disease (CrAg) (then preemptive or therapeutic fluconazole). Site-level implementation of this package will begin in COP20 (FY21). Procurement of all relevant advanced disease commodities will be supported through an agreement with the Global Fund. PEPFAR Mozambique seeks to support advanced disease implementation in 4 central hospitals, 11 provincial hospitals, 4 Pediatric Centers of Excellence, as well as two health facilities previously supported by Médecins Sans Frontières (Hospital José Macamo and Alto Maé Health Center, both in Maputo City)'). However, the final decision of geographic coverage depends on Global Fund allocations.

Once advanced disease has been identified at the site level through CD4 screening (with cryptococcal screening subsequent to CD4 result), further evaluation and clinical management will be addressed through referral to the nearest facility offering the necessary services. Where possible, clinical management should be offered at the site where the advanced disease was first identified. For some patients, this may be the basic primary care level facility where they were first seen. If a health facility does not have CD4 laboratory capacity, samples will be referred to the closest facility with this capacity.

In addition to the diagnostic screening capacity at site-level and the clinical management through a referral network, PEPFAR Mozambique has also committed additional resources to ensure specialized advanced disease clinicians will be available at the provincial level to offer technical assistance, supervision, and mentorship to clinicians providing adult and pediatric advanced disease care.

Table 2.2.1: Proportion of patients with CD4 < 200 in Mozambique

Province	% <=200
Cabo Delgado	25%
Gaza	27%
Inhambane	27%

Manica	20%
Maputo Cidade	28%
Maputo Província	27%
Nampula	24%
Niassa	21%
Sofala	21%
Tete	21%
Zambézia	22%

CD4 below 200 at ARV initiation (FY20 Quarter 3, MOZART)

Improving mental health

Research has shown that mental illness is a barrier to retaining HIV positive patients in care. Identification of patients with untreated mental illness has been recommended to improve clinical management and outcomes of this subpopulation. During COP19, the Common Elements Treatment Approach (CETA) program for diagnosis and treatment of symptoms of mental illness was introduced in five health facilities in Sofala Province. CETA involves application of a mental health symptom screening instrument that has been validated through randomized trials for use in low- and middle-income resource contexts that may rely upon non-mental health providers to deliver HIV care. The instrument (and the accompanying treatment intervention) seeks to integrate screening, care, and treatment for depression, traumatic stress, substance abuse, and anxiety into existing HIV treatment platforms.

Observations from the Sofala sites demonstrated that 50% of PLHIV enrolled in treatment have screened positive for clinically significant mental health symptoms. CETA's transdiagnostic methodology allows for treatment of any of these mental health challenges through a single approach. While the Sofala model in COP19 relied upon lay counselors to perform the diagnostic and therapeutic interventions, in COP20, the approach will be as follows: **screening** will be performed by psychosocial counselors at all relevant health facilities, but **treatment** will be provided by licensed clinical psychologists and technicians from the MISAU Department of Mental Health. MISAU has provided guidance that any expansion of the CETA model should be fully integrated into existing psychosocial support (APSS) programs and guidelines. For example, CETA program staff will provide technical assistance to develop an APSS screening instrument that reflects the elements of the validated CETA instrument. Funds for this activity will be provided through PEPFAR Mozambique implementing partners to include provision of technical support to MISAU at the central level for development of national guidelines, health facility materials, standard operating procedures, provider job aids, cascade trainings and relevant training materials. PEPFAR Mozambique implementing partners will also support hiring a limited number of psychologists and mid-level psychiatric technicians to provide treatment for any patients who have evidence of mental health symptoms at selected sites.

Building on the national male engagement strategy through strategic marketing and youth case management

Though the MISAU Male Engagement Strategy was officially launched in 2017 followed by implementation in selected districts during COP18, the number of men identified, linked, and

retained in ARV therapy remains too low to reach UNAIDS 95-95-95 goals. Approximately 200,000 men (15+ years) are estimated to never have been linked to care or are currently not retained in care. Additionally, individuals who have been lost-to-follow-up for greater than 12 months are historically hard to trace and re-engage in care. Reaching epidemic control requires returning known HIV+ men to care. Once they return, providers and program implementers must prioritize treatment literacy in order to emphasize the value and simplicity of new HIV therapy regimens (namely dolutegravir-based regimens) available in differentiated models of service delivery.

In COP20, PEPFAR Mozambique, in alignment with the MISAU National Male Engagement Strategy, will pursue three additional strategies to improve engagement with this hard-to-reach subpopulation. These strategies are: (i) strategic marketing, (ii) youth case management, and (iii) community monitoring.

Strategic marketing

In Mozambique, there are nearly 200,000 men who have received an HIV+ diagnosis, but who have either never linked, or have left the treatment program. Epidemic control requires that these HIV+ men return to care. Fortunately, Mozambique now has a new value proposition for HIV treatment, offering new differentiated service delivery models, providing new and more effective drug regimens, and empowering patients with knowledge about the benefits of U=U. These new services must be strategically communicated if they are to achieve desired uptake. In close collaboration with OGAC and the MenStar Coalition, PEPFAR Mozambique proposes to rebrand HIV services for men in a way that talks directly to their motivators and barriers to treatment adherence. The strengthening of this brand will require wide stakeholder engagement and must be supported by the expanded community monitoring platform for implementation fidelity. The brand is the service experience, and success is predicated on close coordination with clinical partners and GRM to ensure that cost-effective shifts to the service package are delivered inside the facility in advance of any demand creation activities. This initiative involves: (i) characterization of the emotional needs of the target population; (ii) development of a service-oriented brand, which extends beyond a traditional communications or awareness campaign; (iii) use of mixed outreach media, including TV, radio, digital, flyers, posters; and (iv) re-imagining the consumer-client (i.e. patient) health facility experience to complement the consumer-specific branding. This activity will include the creation of a Marketing Advisory Group (MAG), which will consist of PEPFAR Mozambique representatives, clinical IPs, civil society, PLHIV, and GRM. The MAG will be instrumental in providing strategic guidance to campaign development, execution, and monitoring and brings together a diverse array of perspectives. In addition to involving civil society and PLHIV as a part of the MAG, this strategic marketing activity will also leverage the community-led monitoring platform proposed in COP20 to facilitate community oversight for how well campaign messages are aligned with the facility experience. This activity is intended to reach male PLHIV that know their status and drive them back to care.

Youth engagement and targeted support

Program and research data suggest that the majority of young HIV+ men are sexually active, asymptomatic, and have limited interactions with the health system.[17] According to UNAIDS 2019, 51% of all estimated new infections occur among young men (ages 20-29) and AGYW (ages 15-24). Additionally, 66% of all estimated new HIV infections among AGYW come from young men (ages 20-29). To address these prevalence and transmission findings, PEPFAR Mozambique, in coordination with GRM, will begin targeted support to this age group at 65 facilities with the highest reported rates of LTFU among AGYW and adolescent boys and young men (ages 15-29). These facilities are spread across all 11 provinces, represent 10% of all AJUDA sites yet account for more than one-third of all LTFU among these age bands over the past year. The following activities will be layered and delivered simultaneously at all 65 sites:

Youth Case Management
Targeting individual young men (age 15-29) and young women (ages 15-24). A trained youth manager, who functions at the health facility level, completes an intake process which includes conducting a needs assessment, assigning a peer mentor, and arranging a preventive home visit. As needed, case managers can arrange for referrals for complementary community-based support.

Peer Mentorship
Full-time hired PLHIV peers (1,500) organize regular meetings and support individualized adherence plans. Peer Mentors will also focus on social dynamics, such as supporting disclosure, addressing stigma, promoting treatment literacy, and assisting with clinic navigation. Additional mentorship support can occur through regular age and sex-specific support group meetings.

Group Support
Adolescents living with HIV lead group sessions modeled on Kenya's Operation Triple Zero program and Mozambique's Geração Biz. These sessions are coordinated with clinical care.

Community-Led Monitoring
As detailed in section 4.6, PEPFAR Mozambique is increasing its investments in community-led monitoring platforms to ensure that PLHIV have a role in monitoring and improving the quality of care delivered at the health facility and community level.

2.3 Investment Profile

National Health Budget

GRM allocated 27.98 billion meticais (roughly $4.27 million dollars) to health in the 2019 budget. Relative to 2018, the health sector budget increased by 5 percent. This amount represents a 32 percent increase relative to 2017. The 2019 health sector budget accounts for 10.6 percent of the overall state budget. The health sector budget is essentially internally funded, with on-budget external resources contributing 15 percent. When compared to the 2008 ratio (48 percent internal

[17] GOALS (Age-Sex Model) UNAIDS,2019
Directrizes para Engajament do Homens aos Cuidados de Saúde, 2018

in 2008 versus 52 percent in 2018), it is evident that the Government has steadily increased its contribution to the health sector. It is important to note that the above-referenced ratios of external financing do not reflect off budget-resources. Vertical donor programs that do not directly finance the health sector budget represent between 1/3 and 1/2 of total expenditures per annum in the health sector. The largest 'vertical'-budget donor in Mozambique is PEPFAR. Approximately 79 percent of the health sector budget covers recurrent expenditures, and 21 percent is dedicated to investment expenditures. Not surprisingly, 71 percent of investment expenditures are externally (donor) financed, an increase of 4 percent relative to 2018.

Health sector spending in Mozambique remains highly centralized. Since 2008, the majority of health resources have been executed at central level, with central level institutions receiving an average of 59 percent of the overall health budget. The 2019 budget allocated MT 16.9 billion[18] (61 percent) of health resources to central level institutions (i.e. MISAU, central hospitals, central medical stores), MT 4.6 B (17 percent) to the provincial level (i.e. provincial health directorates, provincial hospitals) and MT 6.1B (22 percent) to the district level (district health directorates).

HIV expenditures

Currently, Mozambique is conducting a national AIDS spending assessment (NASA); the most recent data on AIDS spending is from 2016. The 2017 Global AIDS monitoring report indicates that total HIV expenditures in 2016 amounted to $330 million, a decrease from $343 million in 2015 and $333 million in 2014. PEPFAR Mozambique and the Global Fund are the main source of funds for the HIV response, accounting for approximately 88 percent of HIV expenditures in 2016. Government expenditures in 2014 accounted for $8.5 million in program costs (this figure does not include salary and benefits to HIV/AIDS service delivery providers, pharmacists, laboratory technicians, or other health care staff), which comprises approximately 2.5 percent of total expenditures on HIV, a reduction from $16.2 million (5 percent of HIV expenditures).

Expenditure by cost category

79 percent of GRM´s health budget is dedicated to recurrent expenditures (salaries, procurement of goods and services, operating costs, transfers and financial operations). Only 21 percent of the health budget is spent on investment (capital expenditure) aimed at improving access to health services and quality of care. As a result, resource limitations severely constrain Mozambican health sector capacity to increase health care access and improve infrastructure.

Donors will procure one hundred percent of antiretrovirals between 2018-2020 (equivalent to the current Global Fund allocation period). Global Fund will procure 74 percent and PEPFAR Mozambique will procure 26 percent. These antiretrovirals are sourced through international pooled procurement mechanisms [Global Health Supply Chain Procurement and Supply

[18] Approximately $27.5 million (USD), assuming a 67.14 Meticais to Dollar exchange rate

Management (GHSC-PSM), and Global Fund Wambo]. GRM also relies on donors, particularly the USG, for other HIV commodities such as viral load and early infant diagnosis (EID) reagents.

GRM covers health care worker salaries (estimated at $140 million per annum) and costs related to implementation of health care services (facility maintenance, transport, provision of other essential commodities, and operational costs). To date, 100 percent of ancillary health worker staff salaries (e.g. lay counselors, data clerks) are paid by donors.

Planned Government Contributions

The GRM has committed to spend $10 million/annum on commodities for HIV ($5 million for ARVs and $5 million for test kits), a significant move towards reducing reliance on international partners for the HIV response. The government has also committed to increase domestic funding for health by $25M USD annually between 2018-2020 in accordance with a Global Fund counterpart agreement. However, GRM´s ability to meet this commitment is at risk in light of limited fiscal space caused by an excessive external debt burden. GRM has also acknowledged its current limited capacity to finance additional human resources or improve working conditions, required for quality health care service delivery.

Data availability and Estimations

Health sector expenditures are estimated from annual MISAU budget reports (Relatório de Execução Orçamental) complemented by estimations made by the United Nations Children's Fund (health sector budget briefs). It is important to note that the health sector does not track or report spending by disease category. Reporting on HIV-specific expenditure is based on the National AIDS Spending Assessment (NASA) and the Global AIDS Monitoring Report, as tracked by Mozambique's National Council to Combat AIDS (CNCS), which details HIV funding and expenditure by source, programmatic area, beneficiary population and geographical location. Available data spans 2004-2014.

Next Steps

GRM will not be able to fully cover the costs of its response to HIV and will require substantial support from international partners for the medium term. This is due to two factors. First, population growth (as noted in the 2017 census) and high HIV prevalence (as estimated in IMASIDA 2015) suggest that Mozambique could have significantly more people living with HIV than previously known (~2.2 million in lieu of ~1.6 million). Second, as stated previously, Mozambique is facing a severe fiscal crisis, which limits the government's ability to increase its contribution towards the response. However, the medium to long term economic outlook for Mozambique is favorable. The extractive industry (natural gas) is expected to significantly contribute to state revenues in the next 10-15 years, which should allow the GRM to increase its contribution to the HIV response. As such, it is critical that PEPFAR Mozambique, Global Fund, and other donors

support the planning to achieve sustainable financing strategies to allow GRM to gradually become the primary funder of the HIV response.

Table 2.3.1: Annual Investment Profile by Program Area[19]					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	90.6	68%	20%	2%	10%
Community-based care, treatment, and support	7.9	92%	N/A	2%	6%
PMTCT	22.1	75%	10%	4%	11%
HTS	14.2	81%	12%	4%	3%
VMMC	17.6	99%	1%	0%	0%
Priority population prevention	5.0	44%	7%	7%	43%
AGYW Prevention	3.5	49%	7%	N/A	45%
Key population prevention	6.2	84%	N/A	4%	12%
OVC	16.1	75%	2%	9%	13%
Laboratory	24.2	90%	N/A	5%	5%
SI, Surveys and Surveillance	53.6	72%	19%	6%	3%
HSS	81	N/A	N/A	N/A	N/A
Total	**342**	**N/A**	**N/A**	**N/A**	**N/A**

* Includes VCT, PIT and blood safety (Preventing mother-to-child transmission (PMTCT) testing included under PMTCT)
** Refers to prevention for vulnerable groups, accessible population and prevention for youth
*** National M&E, operational research, surveillance, information technology, research
Source: National Aids Spending Assessment (NASA) for the period 2014 in Mozambique, Conselho Nacional de Combate ao HIV/SIDA (CNCS), September 2016.
NOTE: Updated data from NASA expected in mid-2020.

Table 2.3.2: Annual Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	$80,177,143	30%	70%	0%	0%
Rapid test kits	$7,855450	66%	34%	0%	0%
Other drugs	$5,070,854	30%	0%	70%	0%
Lab reagents	$22,296,793	93%	0%	1%	6%
Condoms	$5,194,215	53%	47%	0%	0%
Viral Load commodities	$111,098	100%	0%	0%	0%
VMMC kits	$4,223,000	100%	0%	0%	0%
MAT	$0	0%	0%	0%	0%

[19] (GRP, National AIDS Spending Assessment, 2012), all amounts in 2012 USD

Other commodities	$0	0%	0%	0%	0%
Total	$124,928,823	47%	49%	3%	1%
The commodities used by the national system are included in the relevant lines (i.e. CD4 is in lab reagents, etc.).					

Table 2.3.3: Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	$19,350,000	$3,680,000	5	-	Focus on end-to-end supply chain strengthening, including procurement of essential commodities for maternal and child health. Funds will bolster the medical commodities delivery systems, focusing on ensuring the accessibility and availability of maternal and child health commodities. Strengthen the GoM's pharmaceutical systems and support G2G in strengthening the medical commodities supply chain. Continue to embed staff at MISAU to conduct institutional-strengthening activities at central and provincial level
USAID TB	$4,450,000	$1,000,000	1	-	Increase demand for quality TB services by implementing household TB screening, monitor referrals for symptomatic individuals and provide treatment support.
USAID Malaria	$27,860,000	$14,682,000	1	$313,688	Increase the availability of essential health supplies by strengthening supply chains, commodity procurement, and creating more supportive environments for commodity security. Funds will support forecasting, procurement, warehousing and distribution of key malaria commodities, including commodities for diagnosis, prevention and treatment of malaria
Family Planning	$14,000,000	$3,000,000	4	-	Increase access to and use of voluntary FP contraceptive methods; procure and deliver commodities for family planning and reproductive health. Funds will bolster the medical commodities delivery systems, focusing on ensuring the accessibility and availability of family planning commodities and;

					strengthen the GoM's pharmaceutical systems and; conclude the development of a Costed Implementation Plan (CIP) for Family Planning (FP) based on the FP Acceleration Plan.
Nutrition	$6,100,000	$400,000	2	-	Support the supply chain for nutrition commodities. Nutrition resources will improve the management of nutrition commodities throughout the system and in target provinces. Funds will bolster the medical commodities delivery systems, focusing on ensuring the accessibility and availability of nutritional commodities.
CDC (Global Health Security)	N/A	N/A	N/A	N/A	N/A
Peace Corps	N/A	N/A	N/A	N/A	N/A
DOD Ebola	N/A	N/A	N/A	N/A	N/A
MCC	N/A	N/A	N/A	N/A	N/A
Other (specify)	N/A	N/A	N/A	N/A	N/A
Total	**$71,760,000**	**$22,762,000**	**N/A**	**$1,543,674**	

2.4 National Sustainability Profile Update

Mozambique has confronted multiple challenges over the past few years. On the fiscal front, the country has been traversing a period of austerity, with limited external donor support. In 2019, windfall, one-time, capital gains taxes from two large oil and gas transactions provided the government with much needed fiscal relief. Nevertheless, the country faces a generalized and growing epidemic, which remains challenging to manage. Mozambique conducted a sustainability assessment in 2019, and the country has made notable progress across all domains.

Sustainability Index Dashboard (SID) Process

The Sustainability Index Dashboard is completed every two years via a collaborative, consultative process coordinated by UNAIDS and PEPFAR, with leadership from CNCS, the civil society platform for health (PLASOC), and MISAU. SID consultations occurred through a series of smaller meetings and one larger meeting involving over 50 participants representing government, multilateral partners, and civil society. The most recent SID (SID 3.0) was approved by the Minister of Health in September 2019.

Sustainability strengths

- Quality Management (8.76, dark green): MISAU has developed and rolled out a number of quality management/quality improvement tools to improve the HIV response.
- Policies and Governance (8.30, light green): The country has approved TLD as a new adult regimen and is making the new treatment regimen available nationwide in a phased manner. Mozambique has laws and policies in place that follow the most recent WHO guidelines that protect victims of domestic violence and protect against discrimination.
- Human Resources: (7.26, light green): MISAU, in coordination with donor partners, has rolled out a data driven human resource allocation system, which deploys staff to health facilities with the highest need. The country has also invested in the human resource information system, which is recognized as one of the best in the region, and which provides reliable data on HRH allocation.

Sustainability vulnerabilities

Laboratory Services (3.93, yellow): Although the sustainability score improved relative to the previous SID (2.83, red), the laboratory system in Mozambique remains challenged at all levels. PEPFAR Mozambique continues to support the laboratory system with a focus on expansion of VL coverage. PEPFAR Mozambique finances 100% of VL commodities and is committed to guaranteeing access to VL for all PLHIV in Mozambique. Other challenges faced include low technical capacity, poor data management and long sample turn-around times. Commodity security and supply chain (4.95, yellow): The GRM has struggled to keep pace with an increasingly complex and data driven supply chain. The current system is inefficient, poorly resourced and heavily dependent on donors. The sustainability index score for this domain fell from 6.18 (SID 3.0) to 4.95. Mozambique remains heavily reliant on donor support for ARV's and test kits, as well as supply chain operational support. The Government has committed to allocate $10 million/year for ARV's. PEPFAR Mozambique and other donor partners will continue to provide technical and financial assistance to identify innovative systems and mechanisms that may help improve the effectiveness of the national supply chain.

In COP20, PEPFARs laboratory investments will shift towards consolidation of gains and institutionalization of national capacity. Mozambique will have a national network of VL laboratories with laboratories functional in 10 of 11 provinces by the end of FY2020. This will ensure that 90 percent of PLHIV will have access to VL and monitoring for viral suppression. The program will complete and implement recommendations of a lab optimization exercise, maintain technical assistance for the national laboratory network, and expand DISA link coverage from 120 facilities to 200 facilities by the end of COP20.

In COP20, PEPFAR Mozambique will also continue to support MISAU with implementation of the pharmaceutical logistics strengthening plan, with a specific focus on intermediate warehouses. By the end of COP20, PEPFAR Mozambique will have completed construction of 2 additional intermediate warehouses. PEPFAR Mozambique will also expand support for third party distribution of medicines to improve effectiveness of the supply chain, as well as improve site level

availability of ARV's. PEPFAR Mozambique will also support rollout of alternative ART distribution models (community, private sector pharmacies) and multi month scripting. Finally, PEPFAR Mozambique will continue to advocate for increased domestic contributions for ARV's and test kits.

Global Fund financial support, under the new grant (2021-2023) funding cycle, will increase by 30%, a much-needed boost for the national response. Domestic contributions are expected to remain stable during COP20. Mozambique is reengaging with on-budget support donors and the International Monetary Fund (IMF), and expects to secure additional financial assistance in 2021. On-budget sector support provided through the *Pro-Saude* common fund is expected to remain constant.

USG collaborates with a range of local partners in Mozambique including non-governmental organizations (NGOs), faith-based, and community-based organizations. The program is transitioning responsibility for selected program components to local partners, whenever technically feasible. PEPFAR Mozambique has also established new partnerships with the sub-national provincial health directorates (Sofala, Manica), as well Niassa and Tete, and will consolidate and expand partnerships with existing local partner (INS, MISAU, CNCS).

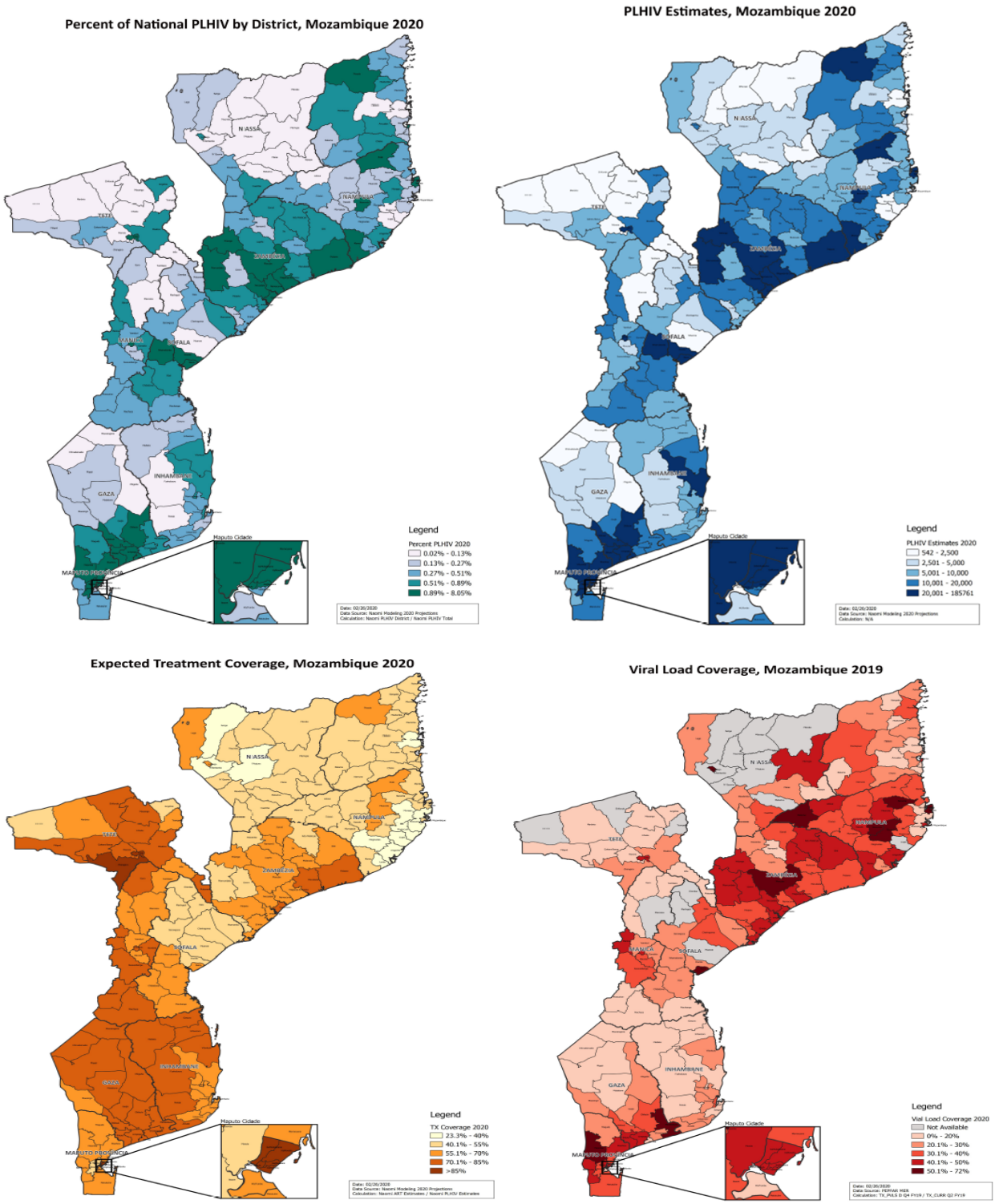
2.5 Alignment of PEPFAR investments geographically to disease

In COP19, in order to maximize the impact of finite PEPFAR resources, an effort was made to concentrate PEPFAR Mozambique investments in a smaller number of health facilities in COP19. A total of 628 sites with direct clinical IP support were prioritized based on having historically provided ART to 90% of Mozambique's patients on ART. The remaining sites were classified as Sustainability sites to continue receiving PEPFAR support through government to government cooperative agreements, both national and provincial. In addition, core services such as antiretroviral therapy and lab sample transport continued to be funded by PEPFAR Mozambique at all ART sites in the country. In this way, PEPFAR Mozambique struck a balance between focused intervention for maximum impact and equity.

Site selection was driven primarily by size but informed by contextual factors. Clinical IPs began working intensively in these sites in a phased manner. Initial FY19 Phase 1 sites were identified by selecting the largest sites with the poorest 12-month retention, highest loss-to-follow up as a percent of TX_CURR, and inclusive of all sites that were already conducting enhanced retention monitoring. Phase 2 and Phase 3 sites were initially selected by sorting sites by descending TX_CURR and selecting the largest sites that made up 85 and 90 percent, respectively, of TX_CURR. In consultation with implementing partners and MISAU, this list was further refined to consider the number of districts supported, roads and their condition, and geographical factors such as rivers. Removal of sites was counterbalanced by the addition of sites with an equal or greater number of TX_CURR so that the benchmarks of 85 percent TX_CURR coverage in FY19 and 90 percent in FY20 continued to be met. Contextual factors were also considered in the addition of sites, such as inclusion of a prison clinic as part of the KP program or proximity to existing AJUDA sites.

In FY19 and 20, the roll-out of intensive clinical IP support to Phase 1, 2, and 3 sites was accomplished. In COP20, these phases are no longer operationally distinct, but rather all 628 sites receive the same support package. No changes were made among the 628 sites. As of this writing, Sustainability sites number 902, making a total of 1,530 ART-providing sites that receive PEPFAR support. In light of its mandate to provide a basic package of services to all Mozambican PLHIV, MISAU may expand the number of Sustainability sites if and when ART services are expanded to new sites.

Figure 2.5.1: Percent PLHIV by SNU, total PLHIV by SNU, Coverage of total PLHIV with ART and Viral Load Coverage by SNU



2.6 Stakeholder Engagement

Host country government

PEPFAR Mozambique is committed to close engagement with the GRM on policy issues, alignment with national priorities, joint planning and implementation, data sharing, coordination and communication with various stakeholders, including implementing organizations, and strategic discussion to support achievement of country goals. Leadership from MISAU, the National AIDS Committee and PEPFAR- led stakeholders' meetings has helped to assure that policy decisions were fully communicated and resulted in action.

Throughout the year, national leadership from the Ministry of Health and the National AIDS Committee meet regularly with PEPFAR Mozambique interagency leadership to make key decisions on policy and strategy both for COP planning as well as implementation. These "Directors' Meetings" happen at least monthly, and more frequently during the COP preparation period. The COP 20 in-country stakeholder retreat began on January 22, 2019 and spanned a ten-day period of intense discussions among key stakeholders to finalize programmatic priorities and targets and develop a united national plan. The Government of Mozambique participated in the COP20 Johannesburg meeting.

PEPFAR Mozambique has national G2G Cooperative Agreements with CNCS, MISAU, the National Institute of Health (INS), and Directorates of Provincial Health (DPS). PEPFAR also provides district level sub agreements and embedded technical advisors. PEPFAR Mozambique staff are active participants in MISAU technical working groups, and engage with DPS to oversee program implementation and partner support through regular site visits, sharing quality assurance and quality improvement (QA/QI) results, Site Improvement through Monitoring Systems (SIMS) reports, and program results (Semi-Annual and Annual Reports). PEPFAR Mozambique also collaborates with the Ministries of Gender, Child, and Social Action (MGCAS), Education and Human Development (MINEDH), Defense (FADM), Foreign Affairs and Cooperation (MINEC), and Economy and Finance (MINEF).

Global Fund and Other External Donors

PEPFAR Mozambique engaged with Global Fund and other key multilateral partners throughout the development of COP20. Members of the Global Fund Country Coordinating Mechanism (CCM) participated in COP20 planning retreats and provided input on key elements. The Fund Portfolio Manager (FPM) attended PEPFAR Mozambique specific planning meetings, including with technical staff, agency leadership, and with MISAU and CNCS for coordination and planning for COP20. PEPFAR Mozambique staff also participated in the Global Fund National Dialogue Meeting and in Global Fund Technical Working Groups and Global Fund workshops to align PEPFAR Mozambique and New Global Fund Planning.

The current Global Fund grant, 2018-2020, is in the middle of the third year of implementation. Current Global Fund grants for this 2018-2020 period are:

1. MISAU joint HIV/TB grant totaling: $254,124,911, with a majority of this funding going towards commodities, but also including some program areas such as health information system (HIS) support, laboratory, training, supervision, and monitoring, and human rights activities;

2. MISAU-TB grant totaling: $41,858,657, supporting commodities, including tuberculosis preventative treatment (TPT), and some programmatic areas such as HIS activities, and training, supervision and monitoring;

3. Fundação para o Desenvolvimento da Comunidade HIV grant totaling: $28,422,994 to support key population prevention activities, AGYW and DREAMS-like activities, and human rights interventions at community level; and,

4. Center for Collaboration in Health (CCS) HIV/TB grant totaling: $30,295,168 to support HIV retention activities and TB case finding at community level, and human rights interventions.

Discussions are ongoing with technical staff and the FPM to coordinate and harmonize activities to avoid duplication. Global Fund staff, including the FPM, SI advisor, and commodity/supply chain leads meet with PEPFAR Mozambique during their periodic programmatic visits in Maputo. PEPFAR Mozambique staff attend Global Fund meetings in-country, including CCM General Assembly and sub-group meetings, communicate with the FPM, coordinate USG technical assistance to the Global Fund, and work to harmonize the PEPFAR Mozambique and Global Fund programs. In COP20, PEPFAR Mozambique will continue to engage with the Global Fund to ensure both programs leverage their respective comparative advantages and eliminate duplication. PEPFAR Mozambique will continue to share information and solicit feedback before and after technical assistance visits and quarterly reporting, and to work closely with the Global Fund to coordinate commodities planning.

Civil Society/Community

As a fundamental stakeholder of the Mozambican national HIV/AIDS response, civil society was actively engaged in all in-country consultations to develop COP20. In addition to routine quarterly meetings to present program data from COP18 implementation, PEPFAR Mozambique invited civil society organizations to participate in all national, international, and multilateral stakeholder meetings. Civil society representatives participated in two national retreats (in December 2019 and January 2020), and led thematic-specific technical working groups that informed the COP20 proposal.

As with prior COP development cycles, PEPFAR Mozambique engaged civil society through the Civil Society Platform for Health (PLASOC), a group representing HIV-focused NGOs and CBOs based in all provinces of the country. PLASOC´s leadership mobilized its constituents to ensure the participation of a vast variety of organizations, including representatives of people living with HIV, and key and vulnerable populations. Faith-based organizations were also in-attendance represented by COREM (Conselho das Religiões de Moçambique), a council that brings together several religious congregations that are present in Mozambique. HIV-related stigma and discrimination reduction, faith-based organizations engagement, HIV health literacy, and community-based monitoring were widely debated, resulting in a list of priority programmatic

activities for PEPFAR to support in COP20. Concurrently, civil society selected representatives to attend the Johannesburg COP20 meeting, in which they were able to engage directly with the S/GAC leadership and present their priorities for COP20 implementation.

PEPFAR Mozambique is committed to assuring inclusive geographic representation, engaging faith-based leadership from a variety of religions, and increasing the presence and voice of PLHIV, youth, and other key and priority populations in all the stages of its programming development, implementation and monitoring. Throughout COP19 and COP20 implementation, PEPFAR Mozambique will continue to meet regularly with PLASOC and civil society representatives and will create opportunities for supporting trainings in data use. PEPFAR Mozambique's Civil Society Engagement team will continue to meet with PLASOC to share information, to solicit input into key programmatic issues and policy decision points, and to assure full participation in COP implementation.

Private Sector

The U.S. Government Public-Private Partnership (PPP) Interagency Working Group, which includes all agencies operating in Mozambique, provides a forum for coordination and sharing of best practices and opportunities for leveraging private sector resources to achieve shared development goals in Mozambique. The PPP Working Group engaged leadership from Exxon Mobile and Anadarko to discuss how they can support the HIV response. Private sector representatives were also invited to the COP retreat. Feedback from these forums and meetings was integrated into PEPFAR's program planning for COP 20. G2G support to CNCS will help coordinate and monitor private sector workplace HIV/AIDS programs. PEPFAR Mozambique will collaborate with the private sector in COP20 by making ART accessible through private sector pharmacies.

3.0 Geographic and Population Prioritization

COP20 planning was driven by a recognition not only that programs should be prioritized, i.e. more intensive focus going to some places and populations than others, but also that they should be tailored, i.e. different interventions being applied to different places and populations. Analysis of the clinical cascade by age-sex disaggregations revealed different problems in different populations; case identification was a serious challenge among children and adolescent boys and young men (ABYM aged 15-29); loss to follow-up was particularly problematic among ABYM and AGYW. Program packages described in detail in Section 4 address both the higher magnitude of care challenges in certain populations and their particular needs. For instance, the youth and young adult case management program is designed to combat high rates of loss-to-follow-up in that population. A strategic marketing program aimed at adult men is intended to bring the high numbers of long-term defaulters in this population back to treatment. The DREAMS program, addressing needs of AGYW, received a 3.5-fold budget increase and expansion from 9 to 32 districts in selected sites.

Treatment targets were allocated according to unmet need as determined through a combination of Naomi and PEPFAR data. The targeting process considered unmet need at the provincial and district levels as well as within groups defined by sex by 5-year age band. These efforts ensured that the most aggressive targets went to the geographies and populations with the largest gaps to epidemic control.

Similarly, voluntary medical male circumcision (VMMC) targets were allocated according to the gap to 80% coverage among 15-29-year-old men, the group where VMMC is expected to have the largest impact on HIV transmission. This resulted in allocation of the highest targets to the provinces of Manica and Tete, where the VMMC program is relatively new, and to Zambezia, where the population is large. Maputo City, Maputo Province, and Gaza, where the estimated coverage is higher, received lower targets. VMMC questions have been added to the Population-based HIV Impact Assessment (PHIA) to ensure that coverage of complete circumcision is truly high in the four provinces where traditional circumcision is thought to obviate the need for a VMMC program, namely Cabo Delgado, Niassa, Nampula, and Inhambane.

Owing to vertical transmission rates that vary from 2-3% in Maputo City and Province to 6-7% in Nampula and Cabo Delgado, the PMTCT program places greater programmatic emphasis on Northern provinces where transmission remains high. A dedicated partner addressing PMTCT is funded exclusively to work in high transmission districts in the Northern provinces of Cabo Delgado, Nampula, and Zambezia.

Table 3.1 Current Status of ART saturation

Prioritization Area*	Total PLHIV/% of all PLHIV for COP20	# Current on ART (FY20 Q1)	# of SNU COP19 (FY20)	# of SNU COP20 (FY21)
Attained	11,226 (0,5%)	36,351	3	1
Scale-up Saturation	N/A	N/A	4	0
Scale-up Aggressive	2,204,513 (95,5%)	1,134,173	122	128
Sustained	N/A	N/A	N/A	
Central Support	92,103 (4,0%)	42,879	32	32

* Military pseudo geography excluded

4.0 Client Centered Program Activities for Epidemic Control

4.1 Finding the missing and getting them on treatment

Case finding is the gateway to effective epidemic control, and bridges HIV prevention and HIV treatment efforts. To accelerate progress towards achieving UNAIDS' 95-95-95 goals, an effective,

targeted, smart, and efficient case finding program is needed in Mozambique. This includes identifying those most at-risk for on-going transmission as well as those at highest risk of HIV infection through scale-up and continued prioritization of index partner and family testing while ensuring attention to privacy and safety. In addition, ensuring the privacy afforded by self-testing can open access to individuals otherwise reluctant to test.

While Mozambique has improved its targeted testing programs for index cases for adults, more work needs to be done to optimize case finding for men and children. The UNAIDS 2019 data show significant gaps in the 1st 90 (61%) and 2nd 90 (42%) among males 15+ years. MISAU recently updated its policy framework to expand index case testing to 10-14-year old individuals, offering an opportunity for robust case finding in this age band.

Therefore, in COP20, Mozambique will: (1) scale-up community-based index case testing to all 628 AJUDA sites, including follow-up for male partners from ANC, and thorough community-level screening of all eligible children and adolescents; (2) provide maternal retesting services in high vertical transmission sites in high burden provinces; (3) introduce lay counselor-led, proactive screening in waiting areas of high-volume sites, using national HIV testing screening algorithms; (4) implement highly targeted male congregate testing in high-incident areas; and (5) generate informed demand for self-testing, as per national policies, in coordination with the Global Fund. These interventions will find and reach children, adolescents and HIV+ adults, adding them to treatment and moving the country towards epidemic control. PEPFAR Mozambique will support the implementation of the new MISAU-approved linkage package, which will address those individuals recently diagnosed but not linked to care via defaulter tracing.

Testing targets for COP20 reflect a more focused approach that was established during the COP19 planning process, in collaboration with MISAU. By the end of COP20, PEPFAR Mozambique expects that index case testing will contribute to one-third of all new HIV+ diagnoses. Policies in Mozambique provide a strong framework for voluntary partner disclosure and mitigation of the risks of intimate partner violence (IPV) related to index case testing. MISAU policy prohibits direct communication with index case sexual contacts and requires index case client consent for community-level support for partner disclosure or index case contact testing. During COP19 and COP20, PEPFAR Mozambique will continue working with MISAU and CNCS to establish a national registry of index case testing-related IPV and will implement a full IPV retraining and certification of all HTS counselors.

During COP20 PEPFAR Mozambique will work closely with the National TB and HIV Programs to better leverage community-based HIV index case testing to include screening for active TB and accompanied referrals to the health facility for confirmatory TB testing.

Mozambique has continued to improve its linkage rates and will continue to address on-going linkage challenges among men. While not all directly related to linkages activities, the following all should positively impact reported linkage rates: (1) expansion of OVC case management to offer

enrollment to 90% of CLHIV on ART at OVC-supported sites; (2) scaling-up of Operation Triple Zero adolescent support clubs at high volume AJUDA sites & peer mentorship models at low performing pediatric sites; (3) introduction of positive peer mentorship for all newly enrolled & high-risk AGYW & ABYM on ART at 65 sites with greatest LTFU; (4) ensuring of MISAU's three-pronged male engagement strategy, male-friendly services and promotion of DSD services (including extended clinic hours, community ARV distribution by APEs) to men; (5) community treatment literacy activities to engage community influencers and religious leaders; and (6) introduction of a strategic marketing campaign to return men living with HIV who are currently not on treatment.

In addition to improving linkage rates, Mozambique continues to expand same-day HIV treatment enrollment. Beyond treatment initiation, ensuring patients are retained on and adherent to treatment is key to achieving epidemic control. Improving retention is the primary focus of the PEPFAR Mozambique portfolio. With MISAU leadership and additional collaboration with the Global Fund, PEPFAR continues to support the GRM's six pillar strategy, which includes: (1) expansion and implementation of differentiated service delivery models; (2) strengthening national HIV quality improvement implementation efforts; (3) expanding and strengthening psycho-social services; (4) combating stigma and discrimination of PLHIV; (5) empowering communities to ensure sustainability; and (6) providing quality HIV testing services to facilitate linkage to care.

In COP20, a major focus will be to continue monitoring the fidelity of implementation of the interventions within the AJUDA logic model, which maps specific activities to each of the six pillars. The team will be working closely with MISAU to ensure that facility-based technical assistance and mentorship leads to expected improvements in retention while simultaneously expanding collaboration with CNCS and civil society to improve the quality of community-based services and interventions.

Optimization of PEPFAR-supported community-focused site-level staff is essential. While administrative support, including chart organization, is critical to facility efficiency, lay workers will continue to be an indispensable cadre to deliver the community psycho-social support package. Patients identified as having an increased risk of adherence and retention challenges during the ART initiation process will continue to receive preventive/supportive home visits in addition to the current facility-based counseling and loss-to-follow-up tracing activities. PEPFAR will work with Global Fund and civil society to ensure that this service is provided as peer support by PLHIV whenever possible, and that lay staff time is prioritized for this activity in a proactive and culturally sensitive manner.

4.2 Retaining clients on treatment and ensuring viral suppression

Retention

With MISAU leadership and additional collaboration with Global Fund, PEPFAR Mozambique continues to support the GRM's six pillar strategy, which includes: (1) expansion and

implementation of differentiated service delivery models; (2) strengthening national HIV quality improvement implementation efforts; (3) expanding and strengthening psycho-social support services; (4) combating stigma and discrimination of PLHIV; (5) empowering communities to ensure sustainability; and (6) providing quality HIV testing services to facilitate linkage to care. PEPFAR will increase investments at site and community levels to improve retention for patients in treatment, including children and adolescents. For COP20, the priority will be to provide client-centered care, targeting special needs for specific groups with a disproportionate burden of loss-to-follow-up (LTFU).

For AGYW (15-24 years) and adolescent boys and young men (ABYM; 15-29 years), PEPFAR Mozambique will support the introduction of a youth case management program. The intervention offers one-on-one peer mentorship to support individualized adherence plans, group support sessions modeled on Kenya's Operation Triple Zero, and a flexible basket of services and referrals through a counselor-administered case management program. The 50 sites with the greatest LTFU in the past four quarters were enumerated both for AGYW and for ABYM. Given significant overlap among the sites, 65 unique sites were identified for this intervention.

To complement the aforementioned case management program, the implementation of MISAU's three-pronged male engagement strategy (facility, community, and workplace) will be rolled out at AJUDA sites within the MISAU prioritized districts. Facility- and community-based efforts should provide men additional support throughout their treatment experience. Workplace programming will be specifically focused on sites and communities where large private sector operators are based.

For pediatric populations, the OVC program will continue its pivot to focusing on children/adolescents living with HIV (in order to meet the COP20 mandate of offering OVC services 90% of C/ALHIV on ART at OVC-supported sites). Expanded mentor mothers programming will be offered in four provinces with high vertical transmission (Nampula, Cabo Delgado, Sofala, and Manica) to improve retention among CLHIV <5 years as well as PLW and adolescents. This will be coupled with the scale-up of Operation Triple Zero adolescent support groups at high volume AJUDA sites (operated by the OVC partner) and one-on-one peer mentorship models at low performing pediatric sites. In COP20, PEPFAR will continue supporting MISAU in offering optimized pediatric ART regimens to all children and adolescents, including DTG as a first-line medication to children >20kg and lopinavir/ritonavir (LPV/r) pellets and granules to infants.

Regardless of age/sex, PEPFAR will continue to support MISAU's expansion and increased uptake of differentiated service delivery models. At the facility, this includes multi-month scripting, expansion of extended hours (either through shift work or shifted hours), one-stop shops for new ART initiates, and promotion of integrated family-based consultations. At the community level, this includes promoting GAACs, using APEs for ARV distribution in all provinces, exploring expansion of mobile brigades beyond the current four provinces based on provincial authorities' interests (and doing so without draining or competing with site-level HRH needs), and scaling-up the implementation of ARV distribution through private-public pharmacies. Two new models

include the implementation of an advanced disease service package at 20 referral sites. These sites, which include regional and provincial hospitals, pediatric centers of excellence, and two former MSF-supported clinics, will offer the advance disease package as a fully integrated service into HIV patient management. Advanced HIV disease screening will take place at all sites, although the scale of this intervention is fully dependent on the procurement of adequate commodities through the Global Fund grant.

PEPFAR Mozambique will also support a standardized mental health screening during the intake process and referrals to mental health professionals where the CETA model, piloted in Sofala, will be adapted and offered. A limited number of mental health professionals will be supported by clinical partners to cope with increased demand for mental health services.

The U=U campaign, supported by WHO, the stigma reduction campaign that PEPFAR will launch in COP20, and various treatment literacy activities focused on community and religious leaders will all complement the noted interventions happening both at the facility- and community-levels.

To ensure that implementation matches expectations, PEPFAR Mozambique will continue to support the National Quality Improvement (QI) Strategy at the national, provincial and site levels and offer mentorship for clinicians.

Viral Load Suppression

PEPFAR Mozambique will support activities in the community and in health facilities to increase provider/patient demand for viral load results. Training of providers through mentorship and on-the-job technical assistance offered during USG and MISAU supervision will be essential in COP20 to ensure appropriate clinical utilization of VL results, with rapid transition to second line therapy as needed. All too often in Mozambique viral load results never get into patient charts and into provider's hands and are not communicated to PLHIV leading unacceptably to avoidable clinical progression and onward HIV transmission. Ensuring patients with unsuppressed viral load are properly addressed is an integral part of the AJUDA response requiring greater attention from both PEPFAR Mozambique staff and implementing partners. To achieve the needed transformation in viral load utilization, all steps in the flow of viral load information will need to be remediated—from improved TAT through expansion of DISA-Link hubs to optimization of electronic systems to organization of patient records to implementation of SOPs. Currently, all VL testing laboratories and instruments are connected to the national laboratory information system (DISA LIS) and all test requests are referred through this system. Accurate VL results are reported instantly to HF facilities through the LIS expediting overall TAT. VL results are also uploaded to the central laboratory database (OpenLDR), from which reports containing VL results and patient demographic information are generated automatically weekly and monthly. These frequent reports are sent automatically to PEPFAR supported health facilities in which respective patients seek treatment, and are also shared with implementation partners. These reports complement the individual patient results that are automatically generated by the LIS and allow stakeholders to easily track and manage patients with unsuppressed VL, as well as for stakeholders to perform

program monitoring. The interconnectivity of OpenLDR and EPTS/OpenMRS that is planned for three provinces in COP20 will not only improve data entry of patients results, which will increase the reported VL coverage in Mozambique, but also will alleviate workflow at health facilities, as manual entry of VL results on EPTS will no longer be necessary. In COP20 we are also planning to expand the DISA LIS to EID POC instruments. Currently, the manual entry of EID results generated by POC instruments into databases has been incomplete and inaccurate, demanding labor-intensive data cleaning procedures. With the implementation of DISA-POC in three provinces, our goal is to capture timely and accurate data that will allow the PEPFAR Mozambique team to guide program implementation and monitor the efficacy of PMTCT strategies. The DISA-POC LIS will also upload data into the OpenLDR automatically, from which health facility /patient level and program reports will be generated. Additionally, identification of patients in need and linking them to quality, age-appropriate, enhanced adherence counseling are key components for COP20 to improve viral suppression rates among pediatric and adolescent patients in Mozambique.

4.3 Prevention, specifically detailing programs for priority programming: During COP20, PEPFAR Mozambique will continue to refocus prevention activities for better epidemiologic alignment, including data-driven geographic prioritization and greater programmatic integration between OVC, DREAMS, and KP activities, and improved coordination with health facilities to support strong linkage and retention into care and treatment.

AGYW Prevention

Since its inception in 2015, the DREAMS program has driven drastic reductions in new HIV infections among adolescent girls and young women (AGYW) in the nine sites where it is being implemented.

In Mozambique, modeling of new HIV infections in nine DREAMS districts (Quelimane, Nicoadala, Beira, Chokwe, Xai-Xai, Chongoene, Limpopo, Matutuine, and Namaacha) indicates that incidence among AGYW has declined by more than 25 percent since 2015.[1] Nonetheless, HIV prevalence within these districts, as measured by testing yield at first ANC among 15-24 year-olds, continues to rank among the highest in Mozambique, at 10.4% as of December, 2019.The geographic implementation will expand from 9 to 32 districts, namely: Limpopo, Xai-Xai, Chongoene, Chokwe, Beira, Quelimane, Nicoadala, Matutuíne, Namaacha and new districts – Matola city, Nampula, Chimoio, Marracuene, Boane, Namacurra, Manhiça, Mocuba, Pebane, Milange, Erati, Maganja da Costa, Moamba, Mocubela, Montepuez, Maxixe, Inhassunge, Ile, Gile, Guija, Lugela, Magude and Caia, representing eight provinces (Gaza, Sofala, Zambezia, Manica, Nampula, Inhambane, Cabo Delgado and Maputo province). For this effect, DREAMS program is receiving a substantial increase in funding from $10.1 million in COP19 to $35 million.

Within the existing 9 DREAMS districts, plans for COP20 will expand coverage to approach saturation, as per OGAC guidelines. PEPFAR Mozambique is working closely with the Global Fund to ensure maximum coverage of AGYW with comprehensive programming in the highest incidence districts. Currently, Global Fund programs for AGYW are implemented by FDC in a total of 45 districts, including 4 current DREAMS districts and another 10 districts slated for DREAMS

expansion in COP20. Within these 14 overlapping districts, PEPFAR and Global Fund will continue to ensure that efforts are carefully coordinated to cover discrete geographic areas to maximize coverage with comprehensive primary prevention programs for AGYW. Planning meetings are currently underway with MISAU, Global Fund and CNCS, as part of the national Global Fund proposal development process, to ensure mutually reinforcing and non-duplicative operational plans for COP20 and beyond.

In DREAMS sites, PEPFAR will continue to implement the layered package of community interventions and clinical services at the "one-stop-shop" adolescent and youth friendly clinics. Integrated services offered at these sites include HIV counselling and testing, contraceptive method mix with emphasis on dual protection, post-violence care, prenatal care, as well as ART initiation, and psychosocial support. Changes to the DREAMS package in COP20 include the addition of PrEP provision for AGYW 15-24 and STI enhanced diagnosis and treatment in the nine legend districts. However, the syndromic approach implementation will be strengthened, as per the MISAU guidelines, in the 32 selected districts. Socioeconomic strengthening interventions with a clear path to both self-employment and wage employment will be tailored to address the deep economic disadvantages facing AGYW in a comprehensive manner.

PEPFAR Mozambique will continue to use the Girls Roster methodology to systematically identify the most vulnerable AGYW, both in new and existing districts based on risk factors such as adolescent pregnancy, extreme poverty, early school drop-out, engagement in sexual risky behavior. Additionally, linkages with the OVC platform will continue to be strengthened to eligible DREAMS beneficiaries to guarantee access to either HIV and violence primary prevention services for adolescent girls aged 9-14, or for the 10-17 who do not need a case management plan.

In addition to interventions above mentioned, a renewed focus for targeting adolescent boys and young men (ABYM) with interventions such as HTC, VMMC, and ART services as well as education sessions on gender norms and masculinity will be included.

In COP 20 all IPs will continue to use an operable layering tool to ensure the completion of at least the full primary package of interventions, monitor the referral and counter-referral system of active AGYW, and report the AGYW_PREV indicator among DREAMS beneficiaries with greater fidelity in accordance with their age and needs. To ensure the most vulnerable girls are identified, all partners conduct a vulnerability assessment in order to screen and to offer enrollment in DREAMS services (see table of interventions by age band below).

Intervention Levels	**AGE GROUPS**		
	9-14	**15-19**	**20-24**

Primary Individual Interventions	• Social Asset Building • HIV prevention sessions • Violence prevention sessions • Educative sessions in Adolescent Friendly services	• Condoms • HTS • HIV prevention sessions • Violence prevention sessions	• Condoms • HTS • HIV prevention sessions • Violence prevention sessions
Secondary Individual Interventions	• Education subsidies • Condoms * • HTS * • Contraceptive Mix • Post-violence care • Other Adolescent friendly services: • ITS screening and treatment • ANC consultation • Linkage to ART	• Education subsidies • Contraceptive Mix • Post-violence care • Social asset building • Other Adolescent friendly services: • ITS screening and treatment • ANC consultation • Linkage to ART • Combination Socio-economic approaches • PrEP	• Contraceptive Mix • Post-violence care • Social asset building • Other Adolescent friendly services: • ITS screening and treatment • ANC consultation • Linkage to ART • Combination Socio-economic approaches • PrEP
Contextual Level Interventions	• Parenting/Caregiver Programming for caregivers of DREAMS beneficiaries • Socio-economic strengthening for families and caregivers • Community mobilization & Norms Change including males • Intervention directed to boys and male partners of AGYW (link to HTS, VMMC, Treatment)		
*Primary package interventions for sexually active AGYW			

Learning from the VACS results, the country will develop a contextualized plan for violence response, in collaboration with the GRM and UNICEF. DREAMS implementation will continue to focus on primary prevention interventions among 9-14-year-olds through evidence-based interventions known to delay sexual debut and to prevent HIV infection and violence. The program will implement interventions for adolescent girls' that provide the foundation to develop healthy relationships, the ability to resist coerced and unwanted sex and to obtain support in the event of coerced sex and development of life skills.

GBV prevention and response will continue to be part of the services offered through DREAMS integrated across the HIV services in COP20. Support is offered for identification, disclosure and referral of AGYW who have faced GBV through:

- Integration of post violence care into the SAAJ services;
- Improved early identification and linkages through confidential and safe services and in the community;

- Improved identification and reporting of violence against children, sensitization for appropriate family communication, norm-changing approaches to revert gender inequitable norms, reduce/end child marriage and other harmful practices; and
- Technical and financial assistance to MISAU to coordinate, monitor and evaluate the GBV response at all levels.

To address the specific needs of youth, the health systems infrastructure needs to be improved. Health centers with dedicated youth friendly clinics (SAAJ), and dedicated and trained staff can offer a full range of services at these one stop shop models of services, that include HIV counseling and testing, ART provision and psychosocial support, STI screening and treatment, contraceptives methods, PrEP, GBV screening and post violence care as well as Prenatal care.

These dedicated Adolescent friendly services (SAAJ) can also respond to the demand created in the communities and schools. The construction of SAAJs is the most cost-effective intervention given that with the same amount of funding the health center benefits from 3 additional consultation and two waiting rooms, thus improving its capacity to respond more effectively and with the desired quality to the needs of adolescents and youth. In COP20 we propose the construction of 35 SAAJ in DREAMS districts improving the coverage of adolescent friendly services in the AJUDA sites.

In addition, in COP20, services from the core package will continue to be provided in school settings through school health corners. Services will include HIV and violence prevention, screening for GBV, provision and distribution of contraceptive methods (limited to condoms and pills), demand creation for HIV testing and referrals. A total of 15 dedicated spaces called school health corners will be rehabilitated/constructed in selected schools.

OVC Programming

The OVC program in Mozambique completed a programmatic shift in COP19 to pivot towards prevention and retention-support activities, focused on the highest-priority children and highest risk adolescents, in the highest burdened areas. PEPFAR will complete this programmatic pivot during COP20 and will also transition OVC program implementation to local organizations in Zambezia, Manica and Sofala provinces, through the introduction of new, locally-led OVC mechanisms, designed to reflect the latest PEPFAR guidance and global best practices in OVC programming.

In order to address the need for large-scale and effective adolescent prevention programming within high-incidence areas in Mozambique, while still offering comprehensive case management approaches to children and adolescents who are most in need of intensive support, PEPFAR Mozambique has opted for a two-tiered OVC program design for COP20:

OVC Comprehensive Program

This will be offered to eligible beneficiaries through Intensive Case Management and a range of services addressing household vulnerability, over longer periods of time. Existing enrollment tools from the HIV Sensitive Case Management package, will be used to identify OVC under age 18 that

are also HIV positive, survivors of sexual violence, LTFU infants at PMTCT, Biological children of HIV+ mothers, children of FSWs, children without parental care, double orphans, children living in child-headed households, and/or pregnant adolescents. These priority OVC sub-populations will be offered a comprehensive package of services to ensure they are healthy, stable, educated and safe. The main entry points for selection and enrollment of OVC for this service package will be the SAAJ or ART enrollment points within AJUDA health facilities, mother-to-child-transmission (MTCT) sectors, community-based HIV testing platforms, GBV service points, and other relevant community or facility-based referral points. Children, adolescents, and young people living with HIV (CLHIV & AYPLHIV) will receive additional support services, based on best practices from other PEPFAR countries such as the OTZ support group experiences, adolescent-friendly adherence clubs per MISAU DSD guidance, treatment literacy counseling, goal-setting, accompaniment of beneficiaries for drug pick-ups and viral load monitoring, and early childhood social and cognitive stimulation for CLHIV under age 5. For children and adolescent beneficiaries of the OVC programs, nutritional support will be provided in different formats. Through community activists, upon screening and identification of needs, children and caregivers will be referred to health facilities nutritional rehabilitation programs in case of severe and moderate malnutrition as per national guidance. Additionally, through the Ministry of Gender, Children and Social action social protection scheme, delivered by INAS, eligible beneficiaries can access food baskets or other social grants. Whenever possible, the OVC programs will seek emergency resources to mitigate severe malnutrition situations.

OVC Preventive Program

OVC enrollment tools will also identify children aged 9-14 who do not fall into the aforementioned categories, but who live within the catchment areas of priority (AJUDA) health facilities, meet other criteria for OVC enrollment, and who are eligible for sexual violence and/or HIV prevention activities. These at-risk adolescents will be systematically recruited and enrolled in educational sessions that use locally tailored and evidence-based curriculums such as *Go Girls! Sinovuyo* and *Coaching Boys into Men* to address vulnerability to HIV acquisition. Main entry points for these OVC would be community platforms, in coordination with community school councils, community child protection committees, and community health workers. This package will also include counseling and referrals for sexual and reproductive health (SRH) and other social services, disclosure counseling for CLHIV, AYLHIV, and children of PLHIV, as well as accompanied referrals for post-GBV care. As needed, additional services will also be provided to these OVC according to individual needs assessments, such as youth-led saving groups and educational subsidies.

Key Populations

Targets and programmatic plans for COP19 were designed to meet case identification and treatment goals for these populations. PEPFAR Mozambique has temporarily halted index case contact testing due to reports of intimate partner violence during COP 19 whilst it is working with OU's in relation to the follow up steps to address this concern. In COP20, PEPFAR Mozambique will continue to focus on improving the identification of HIV-positive KP, linkage to ART, as well as supporting

adherence and retention to treatment, with regular VL monitoring. PEPFAR Mozambique will continue to reach FSWs, MSM, prisoners, and PWID with evidence-based and comprehensive prevention activities (KP_PREV), including demand creation and service provision of Pre-exposure prophylaxis (PrEP). Regarding PWID, due to limited availability of resources, PEPFAR Mozambique will continue to support the demand creation, testing and referral of care and treatment services for PWID in Maputo city while discussions will be held with key stakeholders including MISAU to define the future scope of the PWID support. Through Social media (WhatsApp groups and Facebook chatrooms), regular hotspot mapping, risk-based peer referrals, and use of KP lay counselors PEPFAR Mozambique will collectively identify previously unreached and undiagnosed KP.

MISAU is actively engaged in leading the expansion of a "KP-friendly" service package in all eleven provinces of the country. PEPFAR Mozambique clinical partners will continue to support the implementation of the KP service package during COP20, in addition to training and providing mentorship to health providers and focal points in all relevant sectors. MISAU with PEPFAR Mozambique support will actively engage with clinical partners to assure the correct use of KP-specific data collection tools to track KP service provision across the cascade via EPTS and HIV testing and linkage registers.

HIV-positive KP identified at the community-level will be linked to health services with the support of trained KP peer educators and/or lay counselors, who will offer accompanied referrals to "KP friendly" public health facilities described above. At these sites, KP Peer Navigators will facilitate KP enrollment into ART, and will use a case-management approach to monitor and detect KP defaulters early, alerting Peer Educators of the need for KP-specific follow-up and/or community based support to identify and overcome individual and contextual barriers to treatment adherence. The community implementing partner will monitor each KP referred from the case identification through the viral load status. The Program will continue to coordinate closely with the national HIV program to make clinical services available for KP at the community level through mobile clinics. Community KP partners will work hand-in-hand with clinical partners to ensure that KP diagnosed in the community are appropriately initiated and maintained on ART. In the case of HIV-negative KP the program will offer the adequate prevention package, including referral for PrEP.

Peer Navigators within health facilities will work closely with clinical partners to ensure that all newly enrolled HIV positive KP receive effective psychosocial support ensuring retention and viral suppression. Peer Navigators will help KP develop adherence plans, support goal setting, and will provide practical advice on medication-taking cues, medication refills, clinical visits, viral load monitoring, side effect management.

The Key Populations Investment Fund (KPIF) is an initiative that aims to strengthen the ability of local KP-led, trusted and competent implementing partners (IPs) to contribute to PEPFAR's KP scale-up of differentiated HIV/AIDS prevention, care, and treatment services. The KPIF proposal in Mozambique aims to strengthen three key aspects of KP programing, namely, (1) Increase the availability of high-impact HIV and other health services for KPs; (2) Strengthen the capacity of KP-led organizations and local CBOs to plan, implement, manage, monitor, evaluate and assure the

quality of interventions for KP; and (3) Strengthen individual tracking system and facilitate weekly real time data access and use. It is being implemented in 10 selected districts in five provinces (Nampula, Sofala, Manica, Quelimane, Maputo City and Province) and it will be expanded to additional districts in COP 20. A key area of focus will be the strengthening of the capacity of the selected CBOs to implement programs that respond to KP needs, moving towards a more sustainable model of intervention. Specifically, KPIF implementation in Mozambique will conform to the KPIF requirement that 70% of the overall budget ($3 million) would be invested in KP-led organizations, and non-KP-led organizations will not be sub-implementers. PEPFAR Mozambique will work closely with the IPs to monitor KPIF implementation.

Pre-Exposure Prophylaxis

During COP 20, PEPFAR Mozambique will scale up the geographic reach of PrEP services to all 11 Provinces in 78 Districts, offering PrEP for key populations, sero-discordant couples, adolescents and young women at substantial risk 15+ and for PBFW. During COP discussions it was agreed that MISAU would determine which facilities would be offering PrEP, so the exact facilities will be proposed by MISAU. PrEP screening tools will be used to identify those eligible for PrEP among targeted population groups; clients tested HIV negative and who meet eligibility criteria will be offered PrEP services. PrEP-specific screening and counseling will be fully incorporated into HIV post-test counseling for multiple testing modalities, including community and facility-based index case contact testing, ANC, VCT, and community-based KP testing. Wherever couples are found to be discordant, efforts will be made to ensure that the HIV-negative partner can make an informed decision about starting PrEP, including referrals to nearby PrEP initiation sites.

A one-stop-shop model will be used for PrEP services to support retention; clients will be able to collect medication at either ANC or the HIV clinic. Regular adherence counseling using the PrEP toolkit will be part of the standard service package for all clients. PEPFAR Mozambique will also support the development of national guidelines for PrEP implementation.

Voluntary Male Medical Circumcision

As per PEPFAR guidance, in COP20 the VMMC program will focus on clients aged 15 and above due to safety reasons. In COP 20, the VMMC program will focus on reaching at least 80 percent coverage of 15-29-year-old males, employing targeted demand creation activities to increase coverage, acceptability, and priority referral to services for this age band. Consistent with PEPFAR Mozambique guidance, the National VMMC program will no longer support VMMC for children below 15 years of age except in the limited setting of Shang Ring implementation. All PEPFAR VMMC targets are among males greater than 15 years of age.

An outreach strategy has been instrumental in accelerating progress in districts with slower growth and/or lower coverage; VMMC campaigns, surgical mobile units, and temporary sites will be expanded in COP 20 in targeted areas. Demand creation activities include non-coercive incentives, partner-funded transportation and compensation for lost wages. Compensation and incentive programmatic pilots are being conducted in Maputo City and Zambezia Province. A Human

Centered Design (HCD) approach, that will focus on interpersonal communication to address the barriers to VMMC, will be implemented in all VMMC districts through Community VMMC mobilizers. An incentive pilot involving traditional and local leaders is also being implemented in two districts in Zambezia Province. The full expansion of the above-mentioned demand creation strategies will be implemented from quarter three in COP19.

During COP20, PEPFAR Mozambique will implement the Population-based HIV Impact Assessments (PHIA) survey. One of the goals of the assessment is to ascertain VMMC coverage for better resources' planning and efficiencies. The VMMC portfolio may consider program adjustments based on the PHIA results. PHIA has central funding and a central PHIA team is coordinating it. The modeling data for coverage and saturation does not factor migration for services from neighboring districts. The targets were set using historical performance and program knowledge. Moreover, in districts where modeling data suggest coverage of the target age group is at or above 80 percent, the program will consolidate a transition and maintenance plan program for adolescents aged 10-14 years.

Planning for efficient and effective VMMC interventions is paramount. The VMMC site optimization tool will be used to improve planning by allowing the reallocation of resources, including providers, surgical beds, and other items to sites that need additional support and/or improved performance.

The national HIV testing screening tools are in use in all VMMC sites starting quarter one in COP20. The VMMC program will strengthen referral of clients testing positive for HIV at VMMC sites. All VMMC sites will continue to regularly use the MISAU national HIV testing screening and referral tools and, in addition, keep record of those clients referred to care and treatment. During COP 19, Mozambique will pilot the introduction of Shang Ring device as an alternative for the surgical methods in Maputo and Zambézia provinces, targeting 1000 beneficiaries during COP 19. The results of this pilot will inform the Mozambican Government and USG for the scale up of the use of the device during COP 20.

Emphasis will be placed on adverse event (AE) monitoring and reporting and strengthening of quality assurance and quality improvement activities with the leadership of MISAU. AE monitoring will ensure reporting consistency with MISAU and PEPFAR Mozambique requirements, while simultaneously ensuring that clinical management of AEs remain under the purview of the MISAU.

Gender-based violence

Throughout COP 20, PEPFAR Mozambique partners are expected to provide high quality post-GBV care services and integrate post-GBV services into the PEPFAR clinical cascade, to address GBV as a risk factor for HIV infection and adherence to HIV treatment as well as improve identification of GBV survivors and referrals to post-GBV services. To support service implementation PEPFAR partners are expected to do the following at PEPFAR-supported sites:

- Establish post-GBV care services and allocate the recommended post-rape kits
- Ensure availability of updated GBV algorithms and drugs for children, adolescents and adults
- Designate a person responsible for the GBV program both at the Central and Provincial level
- Ensure that there is a staff member responsible for the GBV program that is familiar with the points of contact for referrals to psycho-social support, police, social welfare services, forensic and legal services within the HF and/or the district
- Identify and properly train healthcare workers responsible for provision of post-GBV services to offer quality services and accurately report and complete forms and registers
- Provide regular mentoring and supervision to ensure quality counseling and services
- Sensitize HF staff (HCW/Auxiliary staff) regarding post-GBV care services within HF and referral processes
- Ensure that the locations where post-GBV services will be provided within HF are defined (ex: SAAJ; APSS; Maternity: one-stop GBV center, etc.)
- Support implementation of GBV QA; M&E and the GBV screening tool as per MISAU guidelines
- Provide post-GBV care services as part of KP prevention package in all AJUDA sites that offer services for KPs
- Report on GBV progress at every IP monthly meeting
- Reproduce and distribute GBV IEC and other materials
- Reinforce demand creation to promote GBV prevention and response at community and facility level
- Train all community providers in GBV (1st Line of Support) such as OVC, DREAMS, KP case managers and mentors in supporting age-appropriate, gender sensitive disclosure of GBV

Preventing Mother to Child Transmission

While Mozambique has achieved high levels of HIV testing (100 percent) and ART coverage (97 percent) in ANC settings, vertical transmission (VT) remains unacceptably high both in program data and modeled estimates. In Q1FY20, positivity in HIV exposed infants under 12 months old children averaged 4.4 percent at AJUDA sites, while Spectrum v5.84 estimated national VT at 13%. According to Spectrum modeling, 38% of Mozambique's MTCT (mother-to-child-transmission) is attributable to incident infections in pregnant and lactating women (PLW), highlighting the need for access to PrEP for high risk pregnant and lactating women as well as timely identification and management of seroconversion. Inadequate adherence to and retention in care of PLW is a central driver of ongoing VT, contributing to a Q1FY20 viral suppression rate for PLW of 81 percent. Viral load coverage for PLW is still suboptimal (51% in Q1FY20). Recent efforts to improve HIV program implementation in PMTCT via the AJUDA response have led to gains in vertical transmission at high volume, priority sites. In Q1FY19 HIV positivity for children <12 months of age at PEPFAR Mozambique supported sites was at 5.5% and has steadily decreased to 4.4% in Q1FY20. Key Northern and Central provinces in Mozambique continue to have <12-month positivity above 5% in Q1FY20 and will receive intensified PMTCT investment in COP20.

Poor retention in HIV care and treatment parallels late presentation for, and poor retention in ANC. IMASIDA 2015 found that only 55% of pregnant women received four prenatal visits prior to delivery. In COP20, PEPFAR Mozambique site level mentoring program will include support for

early identification of pregnancy in alignment with MISAU PMTCT priorities. In COP20, PEPFAR Mozambique will expand SAAJ (integrated adolescent care sites) to improve quality of care for teen mothers and introduce a tailored mentor mother strategy for teen mothers. Other interventions to be introduced in this FY are pre exposure prophylaxis (PrEP) for sero-discordant couples and adolescent girls and young women (AGYW), engagement of religious/community leaders, same day point of care (PoC) VL testing in PMTCT and intensified support by high performing PMTCT partners in higher VT sites.

PEPFAR Mozambique will also continue to support the national implementation of MISAU's Mentor Mother strategy, ensuring that community and facility-based mentor mothers are in place to provide high quality peer support to HIV positive PLW in all AJUDA sites in COP20. PEPFAR Mozambique will continue to support the national implementation of revised psychosocial support and positive prevention instruments tailored to support PLW as well as dissemination of new algorithm and job aids. Via the mentor mother strategy, newly diagnosed pregnant women will receive facility-based preventive and pre-ART counseling, supportive home visits and phone calls, and defaulters will be identified on a weekly basis with community-based follow-up. In COP20, PEPFAR Mozambique will maintain its footprint of mobile brigades in order to provide high quality primary care, ART access and PMTCT in remote communities in provinces with high VT.

Timely achievement of viral suppression during pregnancy and lactation are key priorities. VL results return to clinical charts and clinical use of results during pregnancy and lactation will be renewed priorities in COP20. As detailed in section 4.9, PEPFAR will introduce support for POC VL testing for PLW in COP20. In order to eliminate maternal to child transmission of HIV, PEPFAR Mozambique must strive for the ambitious goal of 100% viral suppression among PLW. Site-level efforts will focus on appropriate implementation of DTG based regimens, appropriate management of high VL to increase timely access to second line therapy for eligible PLW. PEPFAR Mozambique implementing partners are expected to collaborate with government healthcare providers effectively at the site level to ensure that MISAU policies are fully implemented and that Mozambican PLW receive client-centered psychosocial support, positive prevention and timely VL testing with appropriate follow-up.

PEPFAR Mozambique has allocated funds to support the program costs of re-testing of HIV negative breastfeeding women at 4 and 9 months at high positivity sites. Broader PEPFAR Mozambique support for the maternal retesting platform will depend upon Global Fund support and RTK availability in FY21.

Pediatric and Adolescent Populations

Treatment coverage for children and adolescents remains low at 54% and 32% respectively, driven both by inadequate case finding and sub-optimal retention of children and adolescents. While viral load coverage for children under 15 years of age has increased in the past year from 36% to 58%, viral suppression remains much too low at 51% nationally in FY20Q1.

Case finding
Index case testing for children grew markedly over the course of COP18, reaching 30% of all case finding in children as of FY20Q1. The majority of case finding in adolescents continues to take place in ANC and emergency room settings, though PITC and ICT approaches have also been areas of focus. In COP19, poor linkage for adolescent boys is an area of focus, but ongoing work will be needed in COP20 to ensure that boys ages 10-19 are effectively linked to care via the support of counselors and adolescent mentors trained in linkage support. In COP20, PEPFAR Mozambique will support high fidelity implementation of MISAU testing platforms for children and adolescents and increase investment in training and human resources to support community-based testing and referral from schools.

Care and treatment
Pediatric treatment numbers increased from Q2FY19 up to Q1FY20 for both children and adolescents by 3% and 11% respectively; this growth was largely driven by improved retention in the setting of decreased testing volumes during the national testing "reboot" that took place in COP18. In order to continue to improve the quality of services provided and to advance child and adolescent-friendly care models, in COP20 PEPFAR Mozambique will continue to support expanded enrollment of children in differentiated service delivery models (family approach, teen clubs and multi month scripting), expansion of SAAJ, and implementation of extended hours (either through shift work or shifted hours) to accommodate school schedules. In COP20, PEPFAR Mozambique will also increase its site level investment in clinical human resources to ensure that more children and adolescents in high volume facilities in Mozambique can receive care from a dedicated healthcare worker with reinforced training in pediatric and adolescent HIV care. PEPFAR Mozambique and MISAU have agreed to work together to reinforce the mentor mother strategy for children below 5 years of age and increase both support for and monitoring of disclosure activities. As detailed in section 1.3a, the OVC program is continuing a pivot toward support for CL/ALHIV in COP20; PEPFAR Mozambique will mandate well planned coordination between OVC and clinical partners to ensure effective wrap-around services for high risk children in COP20. In COP20, MISAU and PEPFAR Mozambique will also introduce a new cadre of age appropriate HIV+ peer mentors for adolescents and youth in the high volume and high loss sites in an effort to provide more effective psychosocial HIV+ adolescents and youth.

ART optimization Though in FY19 global supply constraints limited Mozambique's ability to fully pivot from NVP-based ART, LPV/r uptake for children <20Kg has increased from 18% in May 2019 to 58% in January 2020. Children and adolescents have also had sharply increased uptake of DTG based regimens which reached 48% in January 2019. NVP uptake fell from 62% in January 2019 to 26% in January 2020. PEPFAR Mozambique will continue to support MISAU in full pediatric ART optimization, including consideration of new pediatric regimens, in CO20.

4.4 Additional country-specific priorities listed in the planning level letter

<u>HIV Treatment</u>

1. ***Scale index testing for adults and children; social network testing in high risk groups; increase partner testing for pregnant women.***

During COP20, PEPFAR Mozambique plans to build on successes to date with the index case testing program, and will ensure that staff at all 628 PEPFAR-supported health facilities are adequately trained on the use of national standard operating procedures for both facility-based and community-based index case testing. PEPFAR Mozambique will strengthen the coverage of male partner testing for HIV+ women diagnosed as part of ANC and post-ANC testing, and will allocate community-based lay counselors to all AJUDA sites to offer household-based index case testing and disclosure support for previously untested adult sexual contacts and all biological children of known PLHIV. Program data and social network referrals will be used to pinpoint high-incident areas for mobile testing approaches to reach adult men in congregate settings (e.g. fishermen gathering points & bars) and link them effectively to care & treatment services.

2. ***Optimized PITC especially for identifying older clients.***

During COP19 & COP20, the PEPFAR Mozambique testing program will scale-up proactive screening of patients in high-volume health facility waiting areas, using national screening tools. This effort will be informed by the promising results of a pilot implemented in Zambezia province, which introduced confidential screening in both urgent care and emergency room sectors, combined with accompanied referrals to facility-based HTS counselors. The Zambezia PITC pilot increased testing and simultaneously increased testing yield, resulting in a 40% increase in the number of new HIV+ cases identified. During COP19 & COP 20, these approaches will be standardized, in collaboration with the Ministry of Health, and implemented in all PEPFAR-supported high-volume health facilities.

3. ***Meeting clients where they are with what they need at each stage of the treatment cascade will be critical to advancing life-long continuity of ART. This requires a better understanding of client needs in order to remove barriers to treatment. MenStar is a coordinated effort to clearly understand obstacles to testing and treatment and differentiate service delivery for men. Leveraging the insights garnered through MenStar, and as a priority MenStar country, Mozambique should implement a core package of services that meet men where they are with what they need.***

As part of the COP20 proposal development process, numerous analyses were performed to better understand programmatic gaps along the cascade unique to specific age/sex groups. With case identification remaining a challenge among men, the HIV testing portfolio has targeted plans to test men through male congregate testing, workplace programs, and an expansion of community-based index client testing. In addition, the implementation of the PITC screening tool has helped focus provider attention on older men, who have consistently shown exceptionally high yield through this modality.

Unacceptably high rates of loss-to-follow-up among young men aged 15-29 (along with women aged 15-24) led to the decision to launch a youth case management intervention at the 65 sites with the greatest LTFU among these two age/sex groups. Through one-on-one peer mentorship coupled with both peer support groups, and a flexible basket of additional services based on individual needs and administered through a trained professional, the case management program offers hope to this difficult to retain population.

Lastly, the HIV treatment program in Mozambique is offering new DSD models, providing new and more effective drug regimens, and empowering patients with new knowledge about the benefits of U=U. Unfortunately, there are nearly 200,000 men who have received an HIV+ diagnosis, but who have either never linked, or have left the treatment program. Epidemic control requires that these HIV+ men return to care. Mozambique now has a new value proposition for HIV treatment, and this must be strategically communicated. In close collaboration with OGAC and MenStar Coalition partner Johnson & Johnson, PEPFAR Mozambique proposes to rebrand HIV services for men in a way that talks directly to their motivators and barriers to treatment adherence. The strengthening of this brand will require wide stakeholder engagement and must be supported by the expanded community monitoring platform for implementation fidelity.

4. ***Continue with COP19 pivot: AJUDA and emphasis on site-level HRH support and client- and family-centered care. Use findings from AJUDA work to develop solutions to barriers, such as providing transportation vouchers for appointments, increased case management, etc.***

In COP20, PEPFAR Mozambique will continue to implement key approaches instituted as part of the COP19 pivot, including an emphasis on site-level clinical and lay staff. These shifts were, and will continue to be, based on site level analyses that incorporate targets, existing staff, and available space.

5. ***Integrate youth and young adult case management and support groups for PLHIV 18-29 and increase enrollment of CLHIV into OVC programs.***

In COP20, PEPFAR Mozambique will roll out a new case management approach for PLHIV 18-29, with a focus on the 50 sites with highest lost to follow up for females 15-24 and males 18-29 (65 sites in total). In addition, the OVC program will continue to increase enrollment of CLHIV, with a goal of offering OVC services to 90% of CLHIV in OVC target sites by the end of COP20.

6. ***Develop strategic marketing approach to improve treatment literacy and encourage LTFU and never linked to return to care. Engage community groups and faith community to improve treatment literacy.***

In addition to the strategic marketing intervention noted above, engaging community and faith-based groups to improve treatment literacy is paramount, including religious leaders living with HIV. Reaching epidemic control will require greater engagement with men, particularly given that

an estimated 73% of the nearly 200,000 HIV-positive men aged 20-29 are not on treatment. PEPFAR Mozambique proposes to engage with faith-based organizations (FBOs) to contribute to advancing the country towards its 95-95-95 targets and stigma reduction goals, with a specific focus on men. Religion is an integral part of Mozambican culture and the presence of numerous religions and sects has led to inconsistent and numerous documented cases of inaccurate health messages. Religious leaders have significant influence and reach and utilizing their existing networks and platform to disseminate positive messages regarding HIV prevention and treatment has the potential for major impact. Men regularly participate in religious activities on Sundays, providing a ripe environment for delivering messages that empower men and encourage them to take control of their own health status while playing a more proactive role in the health of their families.

The proposed approach will consider the following actions:

- Through a collaborative development process that includes CNCS, MISAU, and FBOs, establish priority messages and a communication strategy for HIV literacy and stigma reduction among religious leaders;
- Update the HIV training packages for religious leaders (prevention, treatment, stigma and discrimination, GBV, and U=U), and build the capacity of faith leaders to ensure accurate and consistent messaging;
- Involve the Ministry of Justice, Constitutional and Religious Affairs to prevent/ reduce the spread of false or misleading information on health and HIV by FBOs; and
- Support religious leader participation in Village Health Committee meetings, that represent an opportunity for direct engagement between communities and facilities.

7. Provide advanced disease package at regional hospitals; provide basic package for all to reduce opportunistic infections (OIs).

In coordination with MISAU and Global Fund, PEPFAR Mozambique proposes to expand the advanced disease package from two MSF-supported health facilities to 20 sites, which includes regional and provincial hospitals, pediatric centers of excellence, and the two MSF-supported sites. In addition, all facilities will screen for CD4 and patients eligible for an advanced disease package will be referred to the closest center offering such a service. PEPFAR Mozambique will support the implementation of the advanced disease package while Global Fund will support 100% of the commodities.

8. Maximize 6-month dispensation; consider 12 months for migrant workers.

In COP20, PEPFAR Mozambique will continue to strengthen uptake of 6MDD to decongest health facilities and mitigate frequently cited barriers to treatment adherence. Annual dispensation for specific populations, including minors, will be considered and discussed at the national technical working group level in the coming months. To support this effort, there is a key role for communities to play in both supporting demand creation for 6MDD and for retention in it. In

addition, the expanded community monitoring platform can provide an important oversight for 6MDD and as such community groups will be provided with site-level MMD coverage data.

9. ***Introduce 3HP for TPT; continue to scale TPT broadly.***

The Aurum Institute will begin a pilot of 3HP in July 2020 at 40 sites in Gaza and Maputo. PEPFAR Mozambique support will follow this pilot with the use of 3HP nationally for all TX_NEW in FY21Q4. Prior to the expansion of 3HP, TPT will be completed using INH.

10. ***Increased site level demand for viral load and results return, viral load champions at sites to increase identification of stable clients for 6-month dispensation.***

Viral load coverage has dramatically increased over the past two years, having reached 65% in FY20 Q1. Despite these improvements, there are still significant challenges associated with viral load results return at the facility level. Much of this is associated with inadequate and non-standardized information flow that leads to the misfiling or poor documentation of results. The articulation of clear roles and responsibilities through the results return flow is considered crucial. PEPFAR Mozambique partners have mapped their results return flow and agencies monitor fidelity during site visits. In addition, in collaboration with the HIS Team, new queries are being developed to more accurately monitor the extent to which providers document the viral load result in the patient chart. With the U=U campaign, funded by WHO, soon to launch, there is optimism that both provider and client demand for viral load results will increase.

11. ***Integrate laboratory (DISA) and patient (EPTS) record systems to increase efficiency of results return.***

The interoperability (interface) between the central laboratory data repository (OpenLDR) and OpenMRS (EPTS) databases is currently being tested in Zambezia Province, where EPTS has been centralized at the district level. In COP19, the EPTS architecture is being harmonized among all IPs and in COP20, three provinces will go through EPTS centralization. The interoperability of the OpenLDR and OpenMRS (EPTS) databases will be expanded to these three provinces in COP20.

12. ***Scale successful mental health intervention from Sofala to additional sites to improve retention***.

In an adaptation from the Sofala study, PEPFAR Mozambique will support mental health services through a standardized and robust screening during intake at psycho-social support services. For those clients that screen positive for a mental health illness, they will be referred to mental health professionals for additional services. To support the increased demand, PEPFAR Mozambique clinical partners will be expected to support new mental health staff in limited quantities.

13. ***Improve mentor mother supervision.***

While Mozambique has achieved high HIV testing coverage and treatment for pregnant and lactating women, vertical transmission (VT) remains high nationally at 4.4% at AJUDA sites, while Spectrum v5.84 estimated national VT at 13%. VT challenges are particularly evident in the northern and central parts of the country. The mentor mothers strategy has been an effective driver in improvement in PMTCT outcomes. Implementation of the mentor mother strategy requires appropriate training for mentor mothers, provision of adequate tools, and supportive supervision to promote high quality of implementation. PEPFAR Mozambique will provide intensive supportive supervision in PMTCT and mentor mother strategy implementation at sites and provinces with the highest positivity (Cabo Delgado, Nampula, Sofala, and Zambezia). Other provinces will receive training on improved supportive supervision, both for implementing partners as well as site-level MCH nurses.

14. Pediatric ART optimization.

Pediatric ART optimization has been hampered by the limited availability of LPV/r globally, but with increasing quantities arriving in Mozambique in the coming months, we expect to steadily increase patient transitions with full optimization in May 2020. MISAU has indicated openness to adjusting policy to include DTG 10mg pending final WHO guidance and FDA approval.

15. OVC and clinical implementing partners in Mozambique must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program.

In COP20, the OVC program will continue to increase enrollment of CLHIV, with a goal of offering OVC services to 90% of CLHIV in OVC target sites by the end of the fiscal year.

16. Increase VL capacity and coverage including POC VL for pregnant/BF women.

During COP20, a diagnostic network optimization exercise will take place to identify opportunities to further improve the laboratory network. The PEPFAR Mozambique team is confident that this exercise will identify a need for additional viral load machines, as performance outnumbered capacity in FY19. Point of care viral load among pregnant/breastfeeding women will be supported in the five provinces with vertical transmission greater than 5 percent.

HIV Prevention

1. Scale PrEP to all provinces for KP's, AGYW, serodiscordant couples, and high risk PBFW. Those testing negative in index testing who remain at high risk should be offered PrEP.

PrEP will be scaled up to 78 districts in all 11 provinces. In all 78 districts PrEP will be offered to people at substantial risk, including adolescents 15+, serodiscordant couples, members of key population groups, and PBFW with high risk or with a serodiscordant partner.

2. ***Expand demand creation to support VMMC age pivot.***

PEPFAR Mozambique will immediately expand demand creation to support the VMMC age pivot. This work will continue through COP20.

3. ***Link high risk AGYW to DREAMS; expand DREAMS districts based on HQ guidance and collaboration with GF.***

DREAMS will expand from 9 to 32 districts in close collaboration with GF and GRM 14 of the 32 districts will be shared with GF.

4. ***Increase mobile services for KPs; use IBBS results to target activities.***

In COP20, PEPFAR Mozambique will support MISAU to develop guidelines for mobile clinics/night clinics, which will include provision of both prevention and care and treatment activities. Beginning in COP19 PEPFAR Mozambique established mobile clinics in one province, with planned scale up for COP20.

Global Fund is currently implementing an IBBS focused on female sex workers. The results of this, along with the IBBS being conducted by PEPFAR Mozambique, will provide an additional source of data to adapt KP program strategies in COP20.

Other Government Policy or Programming Changes Needed

1. ***Work with GF to increase condom stewardship and increase coverage of prevention activities for vulnerable AGYW.***

PEPFAR Mozambique is not supporting condoms in COP20 and we are working with Global Fund to quantify the need for condoms, monitor the Global Fund orders, update the supply plans, and implement a condom-specific condom supply chain.

2. ***Continue to scale cervical cancer screening and treatment at screening sites; expand LEEP.***

PEPFAR Mozambique is committed to expanding cervical cancer screening and access to treatment for precancerous lesions in COP20 as detailed in section 4.8 of this document.

3. ***Expand the outsourced medicines distribution system to the entire country to provide timely and cost-effective last mile delivery.***

In COP20 PEPFAR Mozambique will expand the outsourced medicines distribution mechanism nationwide.

4. ***Consolidate the lab specimen transportation network under private sector management.***

In COP20 PEPFAR Mozambique will consolidate the lab specimen transportation network under private sector management in three provinces, with a plan to further expand in COP21.

5. ***Implement a vendor managed inventory approach for viral load reagents to improve availability of commodities and ensure VL platforms are maintained and functioning.***

In COP20, we will begin a Vendor Managed Inventory approach in Maputo province, and expand depending on an evaluation of the results.

6. ***Develop and implement decentralized distribution approaches, in addition to multi-month dispensing, to enhance convenience for clients and improve patient retention and adherence to ART.***

In addition to the implementation and expansion of 6MDD, PEPFAR will expand to all the 37 Farmac private pharmacies in 10 of 11 of Mozambique's provinces.

7. ***Engage with MISAU and CNCS on expanding treatment literacy, stigma reduction, partnerships with faith communities.***

Treatment literacy and stigma reduction are significant areas of focus for COP20. PEPFAR Mozambique will work closely with the Government of Mozambique, civil society organizations, and multilateral partners to implement treatment literacy and stigma reduction activities at all levels of PEPFAR programming. This will include community and facility level interventions via clinical and community implementing partners, community level interventions via CNCS, as well as a larger national campaign via a strategic marketing partner. Faith-based organizations and religious leaders are a vital part of civil society. To ensure greater coordination and better communication between organizations of different faiths and the private and public health sectors, PEPFAR Mozambique proposes to: (a) develop religious and public health literacy through joint trainings and harmonized materials to better align messages; and (b) respectfully engage FBOs in community health work by bringing together religious and public health leaders to disseminate clear and consistent information.

8. ***Further improve/expand EPTS, iDART, and mHealth systems; improve data quality.***

PEPFAR Mozambique has achieved EPTS installations in 500 health facilities with a coverage of 85% (TX CURR) and will reach 92% TX CURR coverage by COP20. iDART coverage currently in 137 health facilities with a coverage of 46% (TX CURR) will reach 92% coverage in approximately 500 facilities by COP20.

9. ***Establish a data sharing agreement with GRM that allows for transparent discussion on site level and warehouse stock availability.***

PEPFAR Mozambique continues to discuss a data sharing agreement with GRM to have official access to important commodity data.

4.5 Commodities

PEPFAR Mozambique coordinates commodity investments closely with the Global Fund and regularly monitors commodity pipelines and funding to ensure appropriate stock levels in country to meet consumption demands. Supply plans are updated quarterly to account for actual consumption levels and orders are adjusted accordingly to maintain 4-9 months of stock (based on consumption) and avoid over or under stocking. Discrepancies persist in TX_CURR and consumption data but have improved from 19.8% in FY18Q2 to 5% FY20Q1, with variations by province.

COP20 commodity investments align with priorities, optimized regimens, and while they represent a 28% increase over the COP19 commodities budget, commodities as a proportion of the overall COP envelope is flatlined at 19%. PEPFAR Mozambique commodity investments cover 100% of the viral load, EID, PrEP, and VMMC needs, while the other commodities depend largely on Global Fund investments, which are not yet known. PEPFAR Mozambique funding covers 14% of the projected ARV financial need and 19% of the projected RTK need. TPT funding focuses on the introduction of 3HP in FY21Q4 and depends on Global Fund support for INH. All funding gaps and potential commodity shortages depend heavily on the outcome of the Global Fund proposal development and approval.

4.6 Collaboration, Integration and Monitoring

Below we describe solutions to address challenges across the entire clinical cascade with specific consideration to:

Strengthening cross-technical collaborations and implementation across agencies and with external stakeholders, including the Global Fund and MISAU

During COP19 implementation, PEPFAR Mozambique engaged with CNCS to develop the scope of work for the new CNCS direct agreement (G2G), with a strong emphasis on sub-grants to civil society to conduct community-led monitoring of HIV services provided at facility and community levels. UNAIDS and several civil society organizations participated in the design of these community-led interventions. UNAIDS and civil society will continue to be substantively involved in implementation of the community-led monitoring approach, including the development of activities and indicators for monitoring progress.

In COP19 and into COP20, together with other multilaterals, civil society and GRM, PEPFAR Mozambique will provide direct technical assistance to GRM on the process of developing the

Global Fund grant application, which is an opportunity to maximize our collective efforts to control the HIV epidemic. In addition, PEPFAR Mozambique will collaborate closely with Global Fund in the 14 districts where both entities fund implementation of AGYW activities.

Strengthening IP management and monitoring and the implementation of innovative strategies across the cascade, with fidelity and at scale, to improve impact within shorter time periods

PEPFAR Mozambique continues to strengthen approaches and processes to ensure highly effective, timely, and standardized partner management is in place to achieve targets and improve identified gaps. All USG agencies have prioritized partner management for achieving results.

All partners report data on key 95-95-95 indicators on a monthly basis and these are jointly reviewed by PEPFAR Mozambique to identify gaps and areas where course correction is needed. In collaboration with the Government of Mozambique/MISAU and implementing partners, PEPFAR Mozambique uses this data to conduct granular site management through an intensive Technical Assistance (TA) approach, as a strategy for partner management by focusing on performance improvement at the site level.

This analysis is conducted on a monthly basis with all implementing partners using advanced data visualization tools consolidated in an inter-agency dashboard. Focused TA and Partner Management site visits to underperforming sites are regularly conducted by the technical teams of all agencies to understand the issues and support the implementing partners in addressing and fixing them.

At the same time, CDC Implementing Partners teams, will conduct the same type of internal TA and monitoring site visits to a subset of sites jointly identified and report on a regular basis.

MISAU provincial and district level teams will also be empowered to conduct partner and site level monitoring visits. Specific improvement plans will be elaborated following site visits and regular monitoring of these plans will be performed.

Implementing Partners will also report on the status of implementation of key priority interventions that will be monitored to ensure fidelity of interventions and adequate scale.

In order to effectively manage implementing partners and improve their accountability, USAID Mozambique has made modifications to all PEPFAR funded activities (as of October 2019) to comply with New Performance Based Requirements for PEPFAR awards that includes: a) High frequency technical data reporting for specific indicators; b) Change the due date of the draft annual work/implementation plans to May 1st of each year, starting May 1, 2020; c) Incorporate greater performance accountability which stipulates that failure to make progress or meet targets and benchmarks may lead to revisions to the award, including instituting a Corrective Action Plan (CAP), or may result in a partial or full termination.

In addition, since October 2019, CDC with the support of the CDC Office of Grants Services now includes performance targets in the Notice of Awards for each Implementing Partner. This additional information provides clear guidance on COP expectations and accountability.

Based on COP20 guidance, effective financial monitoring will continue to take place to ensure that: 1) planned resources (including Human Resources for onsite regular TA) and spending is aligned with technical and geographic priorities as defined in the implementing partner work plan and 2) current spending or projected spending does not or will not exceed the approved operational plan budget. Financial monitoring will be done through rigorous monthly analysis of burn rates, pipelines and accruals of implementing partners and discussed during monthly partner management meetings.

Improving integration of key health system interventions, including HRH and laboratory (VL) activities across the cascade

Health systems priorities continue to be identified, and activities are routinely monitored by cross-cutting working groups to ensure effective resource allocation. In COP19 PEPFAR Mozambique conducted an HRH prioritization and optimization analysis to assist clinical and community partners in allocating HRH based on HIV service delivery needs. In COP20, PEPFAR Mozambique will continue to monitor the staffing allocation and skills-mix at site level compared to MER results.

In order to ensure appropriate HRH support in sites managed by MISAU, PEPFAR Mozambique worked with MISAU departments of HR, Cooperation, and Public Health to define the type of cadres to be hired and criteria for staff allocation during COP19, and this support will continue in COP20. PEPFAR Mozambique will continue to support and provide technical assistance to MISAU on availability and use of data on the HIV cascade system, and will continue to scale up EPTS, iDart and mHealth systems and decentralize EPTS in an additional two SNUs. PEPFAR Mozambique will conduct a laboratory network optimization diagnostic to scale up the VL lab capacity and productivity, improve the referral systems and integration of GeneXpert wherever possible. Another key component will be the expansion and maintenance of lab information systems.

Another key component of systems that will enhance and improve coordination is better integration of logistics and transportation. In COP20 PEPFAR Mozambique will scale up the coverage of the last mile distribution of ARV and other HIV commodities to all provinces, while providing CMAM with continued support for HIV commodities quantification and forecasting, as well as stock management. Lastly, in COP20 PEPFAR Mozambique will award a contract to the private sector for implementation of the consolidated transport of laboratory samples. Continued delivery routes optimization will allow for more frequent and dependable transportation of both commodities and laboratory samples.

Improving quality and efficiencies of service delivery through improved models of care delivery within the community and health facilities

COP20 priorities for improved service quality include strengthening patient-friendly services, improving patient flow and provider workloads within the health facility, and expanding opportunities for community involvement. MISAU's aim for national coverage of all facility and community DSD models is a key mechanism by which these COP20 priorities can be achieved. DSD models available in Mozambique include multi-month scripting, six-month clinical consultations, extended hours (either through shift work or shifted hours), one-stop shops, mobile brigades, APE ART distribution, family health approach, adherence clubs and GAACs[20]. These will be implemented to scale with specific attention to maintaining fidelity to MISAU's six pillars for retention and adherence (see Appendix F). Specific interventions for sex, age, and demographic groups (mobile clinics for key populations; male-friendly services; strategic marketing; expansion of SAAJ[21], etc.) should be carefully monitored during implementation to reach the goal of improved quality of services. PEPFAR, in coordination with GRM, will invite greater community involvement through: (i) launch of community score cards in over ninety health facilities; (ii) pursue greater fidelity in the implementation of the health advocate program; (iii) expand CNCS-led community monitoring, supported by additional PEPFAR small grants to new community-based organizations; (iv) expand community ARV distribution through [22]APEs and integrated primary health care mobile brigades. Greater private sector involvement will be achieved through inclusion of more private pharmacies in the community DSD model platform for ARV distribution. High quality service delivery for these established and novel facility and community DSD models relies upon adequate stock management that ensures continuous availability of pharmaceuticals. Other services that will continue in COP20 include use of lay personnel to provide counseling, adherence support, and tracing of patients who are loss-to-follow-up. Site-level review of program implementation and service delivery will continue through SIMS assessments, as well as through leveraging existing provider mentorship and accountability platforms (supportive supervision, in-service training, and distance learning).

Community-Led Monitoring

Community-led monitoring trains, supports, equips, and pays members of directly affected communities to carry out routine monitoring of the quality and accessibility of HIV treatment and prevention services. Community-led monitoring models can involve quantitative and qualitative data collected via a wide variety of methods that reveal insights from communities about the problems and solutions to health service quality problems at the facility, community, sub-national, and national levels. Another key to the concept of community led monitoring—separating it from other modes of quality improvement—is the full integration of evidence-based advocacy into a cycle that brings new information to the attention of decision makers and holds them accountable for acting on that information. One of the key instruments used in this context is the Charter of Rights and Duties of the Patient. In COP20, PEPFAR Mozambique recognizes the need for monitoring the quality of services provided in health facilities, as a strategy for responding to

[20] Grupos de Apoio e Adesão Comunitária
[21] Serviços Amigos dos Adolescentes e Jovens
[22] Agentes Polivalentes Elementares

violations of patients' rights and duties and improving services at the site level. In addition to improving the quality of services at the site level, community-led monitoring also works to address structural barriers and reduce attitudes related to the stigma and discrimination of patients.

PEPFAR Mozambique, through its internal community and civil society technical working group, has convened several meetings with civil society representatives for the discussion and planning of concrete activities to be included in COP20 planning. The results of the various discussions were as follows: community-led monitoring must be conducted at both the community and the health facility level; the actions taken must be well documented and barriers solved (or addressed) in a timely manner; conditions for people to feel comfortable and safe to share information must be met; and representatives of PLHIV and key populations must be included in all phases of community-led monitoring activities.

In COP20, the Department of State Small Grants under the PEPFAR Coordination Office will allocate its entire Small Grants program budget for this activity, with the goal of funding 15-20 local organizations that will focus exclusively on community-led monitoring. Technical assistance to community-based grantees will be provided by Namati, a local Mozambican organization with expertise in community-led monitoring models. Development of technical criteria for eligible grantees and selection of grantees will be performed in collaboration with PLASOC (PLHIV), CNCS, UNAIDS, USG, and other relevant parties, as will selection of geography and focus for community-led monitoring activities. In keeping with the key principles of community monitoring, the monitoring will be done by PLHIV, KP, and other affected populations. Monitors will receive a living wage, and findings will serve as a basis to understand and then address and correct concerning finding and potentially scale promising/best practices. PEPFAR Mozambique will continue to support community led monitoring via funds to CNCS provided in COP19 but currently unspent. CNCS will provide a grant or grants to additional community organizations for community-led monitoring. In COP20, PEPFAR Mozambique will continue its investment in Namati's current community monitoring platform and provide limited funds to Nweti in order to co-finance community score cards with the World Bank.

Ensuring above service delivery activities are mapped to key barriers and measurable outcomes related to reaching epidemic control;

For the prioritization of above site investments only activities essential to and or contributing to achieving epidemic control were proposed. All activities include clear milestones that allow for comprehensive assessment and monitoring. During COP20 implementation, USG will address insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control, to allow improved data quality and inclusion of early retention data in national HMIS as well as timely and accurate data to inform national HIV response planning and monitor progress towards epidemic control.

To address the issues of poorly trained and insufficient human resources to achieve epidemic control, USG will focus on in-service training through use of distance learning/mentoring approaches.

One perceived key barrier is the lack of appropriate lab data systems needed for scaling up quality VL, EID and/or TB testing. USG will address it through investments in the expansion of DISA implementation and maintenance and DISA EPTS integration. Another key component is the accreditation of three reference labs. Additionally, PEPFAR Mozambique will improve the quality of laboratory systems and services that guarantee accurate and reliable results.

PEPFAR Mozambique will also continue to provide TA to strengthen the quantification, collection, management and use of supply chain-related data for improved end-to-end visibility. Additionally, USG will support the expansion of MMD and the introduction of 3HP by developing policy, training materials, commodity consumption analysis, and routine supply plan updates.

Use of unique identifiers across sites and programs in clinical settings

Mozambique has an existing National Health ID (NID) that is used to support PLHIV initiatives. MISAU introduced the NID in January 2013 and is an official, nineteen-digit client code generated at the health facility level defined by country, province, district, facility, service, fiscal, and patient code combinations. Although unique at the time of its issuance, an individual could have multiple NIDs due to subsequent entry into an existing health facility (e.g., patient lost NID) or other health care facilities. PEPFAR's EPTS, with its scale to almost 85 percent of supported sites, captures the NID as its primary ID with options for multiple entry of other unique IDs (e.g., NUIT). Other PEPFAR Mozambique supported systems, including laboratory, pharmacy, and community care also capture the NID and linking these data sources with the EPTS will continue in COP20. It is a required field in the pharmacy system, iDART, to facilitate linkage between pharmacy and EPTS. It will be a required field in DISA to facilitate linking laboratory results to EPTS. EPTS generates reports to identify duplicate NIDs and patients assigned multiple NIDS. In December 2018, Mozambique passed legislation for the electronic registration of a NUIC (Unique Civil Identification Number) used for the civil registration of births and deaths and production of its official vital statistics. To date, over 400,000 births are electronically registered using the NUIC; with scale situated nationally. Beginning in March 2019, PEPFAR Mozambique HIS introduced the capability for electronically capturing the NUIC, as well. For COP20, PEPFAR Mozambique will collaborate with MISAU, Ministry of Justice and other NUIC implementing donors (i.e., UNICEF, World Bank, WHO) to advance the registration of the NUIC in one province. Expected investment benefits for scale include: facility-community tracking and reduction of silent transfers; authentication of patient-level records and elimination of duplicates; timely exchange and storage of information at varying levels of the National health information system (e.g., DHIS); and, the generation of new information derived from systems linkages for improved HIV/TB program management, case-based surveillance, and policy-making.

Table 4.7.1: ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY20)	Additional patients required for 80% ART coverage	Target current on ART (APR FY21) *TX_CURR*	Newly initiated (APR FY21) *TX_NEW*	ART Coverage (APR 21)
_Military Mozambique	**N/A**	**20,039**	**N/A**	**24,048**	**4,499**	**N/A**
Attained	**11,226**	**30,629**	*<80% coverage reached*	**30,629**	**627**	**273%**
Scale-Up Saturation	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Scale-Up Aggressive	**2,204,513**	**1,312,599**	**451,012**	**1,726,642**	**449,310**	**78%**
Sustained	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Central Support	**92,103**	**47,018**	**26,664**	**69,146**	**23,537**	**75%**
Total	**2,307,842**	**1,410,285**	**435,989**	**1,850,465**	**477,973**	**80%**

Table 4.7.2: VMMC Coverage and Targets by Age Bracket in Scale-up Districts

SNU	Population Size Estimate FY21 (15-29) DMPPT Model	Current Coverage Calculated (FY19 Q4)	Current Coverage (15-29) (FY19 Q4)	*VMMC_CIRC* (FY21)	Expected Coverage (FY21)	Expected Coverage (15-29) (FY21)
Military Mozambique	N/A	N/A	N/A	17,526	N/A	N/A
Alto Molocue	55,676	45,142	81%	1,503	46,345	83%
Angonia	76,625	1,755	2%	2,943	4,109	5%
Barue	29,726	26,339	89%	3,772	29,356	99%
Beira	99,072	86,258	87%	2,100	87,938	89%
Bilene	21,136	17,851	84%	374	18,150	86%
Boane	34,211	28,604	84%	365	28,896	84%
Buzi	27,911	22,664	81%	1,177	23,605	85%
Cahora Bassa	21,386	18,963	89%	4,860	22,851	107%
Caia	25,332	12,841	51%	1,517	14,054	55%
Changara	20,103	17,644	88%	1,532	18,869	94%
Chibabava	20,399	28,170	138%	1,534	29,397	144%
Chibuto	32,911	20,504	62%	933	21,250	65%
Chimoio	60,014	41,187	69%	3,724	44,166	74%
Chiuta	16,336	718	4%	3,033	3,144	19%
Chokwe	32,543	22,012	68%	516	22,425	69%
Derre	17,872	10,916	61%	889	11,627	65%
Dondo	32,103	28,599	89%	550	29,039	90%

Gile	35,137	34,955	99%	3,344	37,630	107%
Gondola	31,396	34,606	110%	800	35,246	112%
Gorongosa	28,366	16,068	57%	1,822	17,525	62%
Guija	13,423	10,769	80%	355	11,053	82%
Guro	15,546	1,053	7%	2,277	2,875	18%
Gurue	67,787	58,023	86%	3,431	60,768	90%
Ile	29,712	36,256	122%	3,481	39,041	131%
Inhassunge	14,185	9,729	69%	372	10,027	71%
Kamavota	52,889	47,843	90%	1,097	48,721	92%
Kamubukwana	51,448	31,596	61%	435	31,944	62%
Limpopo	22,601	16,508	73%	319	16,763	74%
Lugela	28,710	21,739	76%	1,381	22,844	80%
Macanga	26,190	812	3%	3,034	3,239	12%
Machaze	13,945	16,471	118%	2,950	18,831	135%
Maganja Da Costa	22,232	23,109	104%	1,498	24,308	109%
Magude	9,751	8,981	92%	279	9,204	94%
Mandlakaze	20,898	14,076	67%	1,285	15,104	72%
Manica	35,537	45,289	127%	4,493	48,884	138%
Marromeu	25,424	26,635	105%	1,214	27,606	109%
Matola	166,122	111,451	67%	1,864	112,942	68%
Matutuine	7,231	4,972	69%	293	5,207	72%
Milange	96,728	76,838	79%	3,178	79,380	82%
Moamba	14,238	10,356	73%	200	10,516	74%
Moatize	42,669	41,857	98%	8,243	48,451	114%
Mocuba	64,448	62,196	97%	4,063	65,447	102%
Molumbo	52,537	30,187	57%	1,766	31,600	60%
Mopeia	24,914	19,283	77%	1,047	20,120	81%
Morrumbala	59,580	35,798	60%	702	36,360	61%
Mossurize	30,944	15,320	50%	2,373	17,218	56%
Mutarara	26,928	21,179	79%	2,207	22,945	85%
Namacurra	33,115	22,601	68%	1,064	23,452	71%
Nhamatanda	45,435	34,112	75%	1,201	35,072	77%
Nicoadala	20,605	42,931	208%	2,593	45,005	218%
Nlhamankulu	20,605	35,190	171%	700	35,750	174%
Pebane	33,674	23,663	70%	960	24,431	73%
Quelimane	56,148	78,374	140%	2,848	80,652	144%
Sussundenga	26,990	20,146	75%	3,773	23,165	86%
Tete	50,923	31,752	62%	6,067	36,605	72%
Vanduzi	18,884	1,280	7%	3,033	3,706	20%
Xai-Xai	21,923	17,248	79%	657	17,774	81%
Total/Average	**2,083,174**	**1,621,416**	**78%**	**131,547**	**1,712,632**	**82%**

Table 4.6.3: PP_PREV Target Populations for Prevention Interventions to Facilitate Epidemic Control **Target population for PP_PREV is AGYW**		
SNU	**Population Size Estimate (scale-up SNUs)**	**FY21 Target**
_Military Mozambique	N/A	23247
Limpopo	13,918	4661
Xai-Xai	14,240	4769
Beira	52,230	19760
Nicoadala	18,447	3322
Quelimane	35,168	8843
Chokwe	20,237	7003
Chonguene	10,809	3620
Namaacha	3,370	391
Matutuine	2,306	188
Cidade da Matola	66,226	10761
Nampula	48,618	7901
Chimoio	23,066	3748
Marracuene	12,689	2159
Boane	11,511	1969
Namacurra	11,102	1902
Manhica	11,903	2227
Mocuba	23,638	3841
Pebane	9,375	1524
Milange	33,415	5430
Erati	10,475	1702
Maganja da Costa	7,394	1202
Moamba	4,334	705
Mocubela	6,246	1015
Montepuez	8,681	1411
Maxixe	5,127	833
Inhassunge	4,366	709
Ile	6,243	1014
Gile	9,965	1619
Guija	5,011	815
Lugela	5,783	940
Magude	1,950	316
Caia	11,362	1846
Changara	25,406	98

Gondola	8,731	98
Guro	11,847	98
Inharrime	23,391	98
Mandlakaze	30,286	98
Massinga	25,628	98
Mecanhelas	4,789	98
Metarica	21,192	98
Morrumbala	13,292	98
Morrumbene	5,686	98
Muecate	7,778	98
Nacaroa	23,172	98
Rapale	21,823	98
Ribaue	24,849	98
Zavala	26,435	98
Bilene	40,302	99
Chibuto	27,504	99
Gurue	4,283	99
Homoine	17,903	99
Malema	19,511	99
Sussundenga	4,046	124
Cahora Bassa	36,718	195
Moatize	7,170	195
Chiuta	6,761	196
TOTAL	**947,704**	**134,068**

Table 4.6.3a: KP_PREV Target Populations for Prevention Interventions to Facilitate Epidemic Control
****Please note population size estimates for KP are not available at the district level****

SNU	Population Size Estimate (scale-up SNUs)	FY21 Target
Alto Molocue	N/A	169
Ancuabe	N/A	186
Beira	N/A	2,367
Bilene	N/A	786
Boane	N/A	179
Chimoio	N/A	1,062
Chiure	N/A	544
Cuamba	N/A	92
Dondo	N/A	652
Gondola	N/A	337
Gurue	N/A	283

Inhambane	N/A	1,448
Inharrime	N/A	38
Inhassoro	N/A	321
Kamavota	N/A	450
Kamaxakeni	N/A	692
Kampfumu	N/A	1,724
Kamubukwana	N/A	636
Lichinga	N/A	304
Mabalane	N/A	188
Mandimba	N/A	92
Massinga	N/A	250
Matola	N/A	3,912
Maxixe	N/A	809
Meconta	N/A	736
Metuge	N/A	124
Milange	N/A	128
Moamba	N/A	395
Mocuba	N/A	338
Mogovolas	N/A	304
Montepuez	N/A	427
Nacala	N/A	2,499
Nacala-A-Velha	N/A	343
Nampula	N/A	4,987
Nicoadala	N/A	385
Nlhamankulu	N/A	541
Pemba	N/A	728
Quelimane	N/A	2,333
Tete	N/A	1,189
Vanduzi	N/A	125
Vilankulo	N/A	329
Xai-Xai	N/A	1,036
TOTAL	**N/A**	**34,468**

Table 4.7.4: Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children (2019)**	**Target # of active OVC (FY21Target) OVC_SERV**	**Target number of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC***
Machaze	1,578	2,766	2,627

Gondola	1,900	3,437	3,267
Sussundenga	1,990	3,581	3,401
Barue	2,281	3,998	3,799
Inhassunge	1,977	4,007	3,807
Molumbo	2,325	4,264	4,050
Morrumbala	2,269	4,266	4,055
Marracuene	1,167	4,491	4,267
Ile	2,243	4,815	4,574
Dondo	2,814	4,977	4,730
Mossurize	3,014	5,280	5,014
Chimoio	2,093	5,684	5,398
Buzi	3,254	5,760	5,469
Pemba	2,348	5,770	5,479
Maxixe	920	6,041	5,740
Zavala	1,005	6,055	5,751
Nhamatanda	3,471	6,142	5,835
Pebane	3,274	6,822	6,480
Manica	3,920	6,870	6,527
Mandlakaze	2,097	6,925	6,579
Maganja	3,460	7,096	6,740
Chonguene	1,590	7,117	6,759
Montepuez	2,655	7,285	6,919
Alto Molocue	4,102	7,523	7,147
Vilankulo	1,287	7,637	7,256
Milange	2,594	7,682	7,300
Gurue	4,149	7,713	7,328
Monapo	1,872	7,734	7,347
Bilene	2,412	7,857	7,465
Namacurra	3,932	8,284	7,871
Boane	2,617	8,347	7,930
Kamavota	688	9,043	8,589
Tete	1,546	9,809	9,317
Nicoadala	4,447	10,049	9,546
Xai-Xai	2,339	10,359	9,842
Mocuba	4,552	10,412	9,889
Kamaxakeni	793	10,425	9,902
Chibuto	3,205	10,529	10,000
Massinga	1,753	10,535	10,008

Moma	2,557	10,566	10,037
Moatize	1,717	11,026	10,476
Limpopo	2,837	11,869	11,275
Quelimane	4,002	12,099	11,493
Kamubukwana	1,026	13,488	12,813
Chokwe	3,507	15,305	14,540
Nampula	3,347	18,084	17,179
Nlhamankulu	1,798	23,633	22,452
Beira	10,061	28,443	27,021
Matola	20,238	61,701	58,614
Changara	823	106	100
Guro	790	106	100
Homoine	813	106	100
Inhambane	897	106	100
Inharrime	695	106	100
Inhassoro	553	106	100
Jangamo	665	106	100
Malema	1,251	106	100
Mecanhelas	1,628	106	100
Metarica	324	106	100
Morrumbene	1,078	106	100
Muecate	572	106	100
Nacaroa	714	106	100
Rapale	1,385	106	100
Ribaue	1,394	106	100
Cahora	939	133	126
Chiuta	620	133	126
Matutuine	937	207	196
Namaacha	993	211	200
Magude	1,377	277	263
Moamba	1,500	485	460
Lugela	1,820	506	481
Guija	1,286	545	517
Mocubela	2,242	653	620
Gile	2,461	872	828
Erati	2,230	917	871
Caia	1,715	994	944
Manhiça	4,342	1,201	1,141

TOTAL	**183,067**	**482,325**	**458,177**
* Target number of active beneficiaries whose HIV status is known does not include known status among graduated beneficiaries			

4.8 Cervical Cancer Program Plans

Cervical cancer is the first cause of cancer-related death among HIV positive women in Mozambique; yet it is preventable and treatable. PEPFAR Mozambique will scale up efforts in COP20 to ensure efficient implementation of cervical cancer screening and treatment services in alignment with PEPFAR guidance and MISAU policies. Cervical cancer prevention (CECAP) services in Mozambique are offered through a single visit approach (screen and treat), adopted by MISAU to ensure women are appropriately screened and offered treatment or referral in the same visit. At the health facility level, cervical cancer prevention care is integrated with reproductive health services, which are co-located with HIV care and treatment services in some health facilities. Patients with advanced pre-cancerous lesions and apparent invasive cancer lesions are referred to secondary and tertiary hospitals where they have access to LEEP and surgical management. PEPFAR Mozambique rapidly scaled cervical cancer programs in FY19, screening 76,061 HIV+ women in a total of 637 sites and achieving 124% of PEPFAR's annual national screening target. Despite these gains, the quality of screening and linkage to treatment remain a challenge. In FY19, only 58% of women who screened VIA+ had access to treatment**.** In COP20, PEFAR will invest a total of $5.5M to deepen its support for cervical cancer programming in Mozambique. The COP20 cervical cancer investment will focus on direct support to the MISAU's national cervical cancer program for policy development and supervision, supplies for pathology laboratories to enable cancer diagnosis. With PEPFAR Mozambique funds, clinical implementing partners will invest in essential infrastructure and commodities for CECAP and support personnel providing CECAP services as well as relevant TA and supervision. In COP20, LEEP access will expand from 10 to 19 sites nationally with PEPFAR Mozambique support.

4.9 Viral Load and Early Infant Diagnosis Optimization

COP20 will continue to fully support VL and EID testing on conventional platforms in all ART sites nationally within the existing national reference laboratory network as well as utilizing the m-PIMA POC instruments for EID.

Multiplexing

To further increase access and improve VL testing coverage for PLW, the PEPFAR Mozambique team is engaged in technical discussions with relevant MISAU and HQ programs for the operationalization of VL/TB GeneXpert and VL/EID m-PIMA multiplexing. The strategy under discussion will allow VL testing for PLW and children <5y/o in the same facilities where GeneXpert or m-PIMA instruments are located and there is excess testing capacity beyond TB and EID testing, ideally allowing PLW and children <5y/o in multiplexing facilities to receive a VL result on the same day as their consultation. DNO modeling scenarios are underway and will provide the basis for a cost-benefit analysis, in which the acquisition of additional instruments could be considered for

meeting patient demand. The acquisition of additional instruments will be prioritized through reagent rental agreement contracts, but in absence of this modality, the upfront purchase of m-PIMA instruments could be considered when well-justified. In FY20, the PEPFAR Mozambique team is working with MISAU to implement improvements and creating efficiencies on processes and procedures for expediting VL results performed on conventional instruments. These improvements will continue through FY21 and include the integration of m-PIMA instruments in the Laboratory Information System (LIS / DISA), which will improve data accuracy and facilitate program management. In FY21, all ART sites will be covered by either conventional or POC instrument testing. For COP20 no new sites or geographic areas are projected for VL and EID. However, some sites could transition from conventional to POC or near POC instruments for VL testing based on DNO analysis and prioritization of areas with higher vertical transmission of HIV from HIV+ women to their infants.

Funding

PEPFAR Mozambique funds in COP20 will cover 100% of VL testing needs and include the multiplexing strategy on POC or near POC instruments; provisional budgets include an allowance for the increased cost of POC testing in comparison to conventional platforms.

Donor transitions

Unitaid IP's (CHAI and EGPAF) transitioned out of support for the m-PIMA EID POC platform in COP19 during which time relevant contracts were transitioned to PEPFAR Mozambique. MISAU currently manages EID POC platforms with PEPFAR Mozambique support. Currently all m-PIMA instruments are covered under a maintenance contract or extended warranty, but these contracts require renewal in COP21.

Table4.9.1: Service packages for programs whose geography is not driven by HIV treatment targets		
Technical Area	**Geography**	**Service Package**
VMMC	• Program conducted in the following 7 provinces: Maputo City, Maputo Province, Gaza, Sofala, Manica, Tete, Zambezia • Distribution of targets determined by VMMC coverage estimates	• Offering of HIV testing services (HTS). Testing services should be targeted to highest risk beneficiaries based on use of HTS screening tools • Screening and treatment for STIs • Male circumcision (surgical or device removal of the foreskin) for males 15 years and older • Identifying and implementing active referral and linkages of HIV-positive men to HIV care and treatment and STI services • Demand creation targeting males 15 years and older including non-coercive compensation and extended hours services (either through shift work or shifted hours) • Optimal AE monitoring and reporting
Key Populations	• Program conducted in 9 provinces; subset of priority site catchment areas in 55 districts; based on KP size and coverage estimates (e.g. Global Fund presence), as well as historic KP testing yield • Distribution of targets determined by KP prevalence and coverage estimates. • Target Populations: FSW, MSM, prison populations; and PWID	• HIV prevention educational and behavior change interventions, • Counseling and testing for HIV • Identification of HIV+ KP through screening tools, linkages to care and treatment, adherence counseling and retention support, VL monitoring, referrals for STI screening and treatment, and referrals to other services (legal, social, health, etc.) • Through the clinical partners, implementation of the KP guidelines at the facility level, through training (in-service training, clinical mentoring, technical support and supervision), dissemination of KP guidelines, screening tools, and algorithms. KP cascade monitoring through monitoring of the newly approved HTS and treatment tools, and effective integration of KP indicators into EPTS as well into health facility monitoring of PLHIV • Clinical services provided for KP at the community level through mobile clinics including:

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Screening for TB
Screening for Cervical Cancer and Prostate cancer
Family planning methods
Offer of Pre-Exposure prophylaxis (PrEP). In addition, KP community partner will engage in sensitization and PrEP demand creation as well as literacy in adherence counseling in provinces where PrEP is being provided to KP
Post-exposure prophylaxis (PEP) as per MISAU guidelines
GBV package
Condoms and lubricants
In prisons focus on HIV and TB screening upon entry as well as supporting the continuum of education and treatment services during incarceration, per HTC guidelines, and referral into care and treatment after release
Provision of community-based HIV counseling and testing, prevention package and referral of PWID to clinical services

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<td>DREAMS</td>
<td>DREAMS is expanded from 9 districts in 4 provinces to 32 districts in 8 provinces. DREAMS activities are restricted to sites within DREAMS districts with direct clinical IP support and their catchment areas. Site level coverage in districts where GFATM operates still to be decided.
Please see the list of DREAMS districts for COP 20 below.
<table>
<tr><td>Cabo Delgado</td><td>Montepuez (new)</td></tr>
<tr><td>Gaza</td><td>Guija (new)
Chokwe
Limpopo
Xai-Xai
Chongoene</td></tr>
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Improve diagnosis and treatment of STIs among AGYW and their partners. Scale up the focus on adolescent girls 9-14-year-old by implementing age appropriate and evidence-based HIV and Violence prevention interventions and leveraging OVC program to expand the variety of services offered
Maintain the package of services for most vulnerable 15-24-year-old, with a more holistic focus and a highly targeted approach within this age band
Improve economic opportunities for AGYW; Strengthen government policies and strategies to ensure comprehensive HIV and violence prevention in schools.
Support creation of an action plan following the results of the VACS study

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OVC	● Program conducted in 10 provinces; subset of priority site catchment areas in 50 districts; based on geographic pivot and CLHIV estimates	● Full package of home-based interventions and referrals offered to OVC, based on household vulnerability assessment, with increased focus on providing services, including counseling and testing, to CLHIV with family or socio-economic situations that cause barriers to retention and adherence on ART. Strengthen case management services for CLHIV and families affected by HIV including direct nutritional support and economic strengthening services ● Provision of primary sexual violence and HIV prevention services, which include counseling and referrals for SRH, disclosure counseling, referral to post GBV care, and using Go Girls and Sinovuyo. When necessary, additional services for AGYW will be provided such as youth led savings groups, referral to social action direct services and school enrollment and education subsidies
PrEP	● PrEP expansion from 3 to 11 provinces (38 to 74 districts).	● PrEP eligibility screening incorporated into HIV post-test counseling ● PrEP will be offered to serodiscordant couples, key populations, and Pregnant and Breastfeeding Women (PBFW) and adolescents aged 15+ at substantial risk. Demand creation interventions including the utilization of the approved MISAU IEC package ● Training and mentoring of health facility staff to provide and monitor PrEP, perform adherence counseling, and manage AE

4.10 Establishing service packages to meet targets in attained and sustained districts

In COP20 PEPFAR Mozambique and GRM have collaborated to define the core service delivery package for HIV care and treatment services at AJUDA and Sustainability sites (Table 4.9.1) as well as the core service delivery elements for programs not guided by HIV treatment targets (Tables 4.10.1).

Table 4.10.1: Service packages to support HIV treatment in clinical IP supported sites and sustainability sites*

Technical Area	Clinical IP Supported Sites (90% TX_CURR, 628 Sites)	Sustainability Sites (10% TX_CURR, 719 Sites)
Quality Improvement	● Joint USG/MISAU/DPS & DDS data driven performance management ● IP-supported management and leadership at facility, provincial and district levels through direct supervision, intensive technical assistance and focused in-service trainings ● IP support for focused quality improvement activities: o Normalize weekly ART Committee implementation and support use of data at site level to drive decision making o Enhanced monitoring via monthly reporting to MISAU/USG/IP o Support implementation of clinical, APSS and ATS mentorship program o Support ongoing ART optimization including second line regimen o Support implementation of facility level QI action plan o Establish quarterly provincial QI collaboratives for knowledge exchange, with provincial review of monthly/weekly performance and change management at sites with clinical IP support o Identify QI facility, provincial and district champions to support knowledge management and QI collaborative leadership o Inclusion of persons living with HIV in HF co-management committee meeting/ART committee	● Share QA/QI tools for DPS to replicate trainings at central support sites ● Central site participation in quarterly QI collaborative can be funded via MISAU's Cooperative Agreement or DPS coag funds, if prioritized by MISAU

HIV Testing	• Implement facility and community-based index case testing in all 628 AJUDA sites, including follow-up for male partners from ANC, community-based testing and intensive linkage support among key populations, and thorough community-level screening of all eligible children and adolescents. • Provide maternal retesting services in high vertical transmission sites, as determined by provincial level data as well as available budget. • Introduce lay counselor-led, proactive screening in waiting areas of high-volume sites, using national HIV testing screening algorithms. • Implement highly targeted male congregate testing in high-incidence areas, based on available budget. • Generate informed demand for self-testing, as per national policies, in coordination with the Global Fund • Establish quarterly performance evaluations of all testing counselors	• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding
Linkage	• Site-level clinical mentorship on correct and consistent use of new HTC registers. (which includes linkage) • Support the dissemination and use of national SOPs for follow-up of non-linked PLHIV • Quarterly site-level linkage assessment with gap analysis and action planning	• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding
Retention	Support for MISAU 6 pillars of retention: • Differential Service Delivery (DSD)	• Roll out CNCS community/ psychosocial support package via G2G funding

	○ Clinical mentorship and support for DSD implementation and scale up including multi-month drug dispensing, spaced consults (fluxo rapido), family approach, GAAC, adherence clubs, one-stop models and community ARV distribution models ○ Community-based ART distribution via Agentes Polivalentes Elementares (APEs) in all provinces ○ Private pharmacy ART distribution extended to entire Farmac network spanning 10 provinces ○ Adoption and scale up of 6MDD within COP19 and COP20 ○ Extended service hours via shifts, e.g. in emergency rooms, scale-up to be coordinated with MISAU ○ Scale up of IDART and IDART interoperability with EPTS to AJUDA sites to support multi-month drug dispensing ○ Maintain mobile brigades with community ARV distribution in 4 provinces ● Psychosocial support ○ Direct mentorship to strengthen the quality of psychosocial support including counseling, preventive calls, and home visits as well as dissemination of new APSS instruments ○ Programming for defaulter prevention and reintegration ○ HR footprint to support full APSS implementation	

	○ Strengthen existing MISAU mental health system by increasing referrals and mental health treatment capacity of psychologist cadre ○ Quality Improvement (see dedicated QI section) ○ Stigma & Discrimination ▪ Combat stigma through national media campaign ▪ Provide in-service training on human rights in the setting of HIV and KP via DPS coags and IP funding ▪ Strengthen provincial PLHIV networks and civil society platforms through funds to CNCS ▪ Reduce stigma among health providers through mentorship to ensure more comprehensive access to HIV quality services for all subpopulations ▪ Strengthen local traditional leadership platform to support community dialogues on stigma and discrimination through funds to CNCS ▪ Support development and implementation of health communication training package for FBO's and religious leaders focused on prevention and treatment literacy as well as stigma reduction	

	○ Community ▪ Strengthen platform for facility/community coordination • Strengthen quality of community health committee • Community-led monitoring of health facility performance • Strengthen quality of HF co-management committee to ensure participation and engagement of community members ▪ Implementation of treatment literacy strategy including messages on prevention, treatment, and U=U: ▪ Central development and adaptation of materials ▪ Community radio ▪ Community mobilization ▪ Social media	
Additional Considerations for Adult Care and Treatment	● Support routine screening and improved management of sexually transmitted infections, opportunistic infections (OI), malnutrition, and gender-based violence (GBV) ● Implementation of optimized ART regimens including DTG	● Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR Mozambique Site-level HRH at central support sites will be determined by MISAU's COP20 funding ● IP support for VL/EID sample transport

	• Support implementation of advanced disease package at targeted sites based on commodities availability • Support implementation of male engagement strategy at targeted districts and sites based on MISAU guidelines • Fully implement VL monitoring (including early identification of suspected treatment failure & prompt transition to second line when needed) • Provision of facility-based staff to ensure availability and flow of laboratory specimens and lab-results and improve use of laboratory results by clinical staff	
Additional Considerations for Pediatric Care and Treatment	Same as Adult Treatment (see above), plus: • Support implementation of MISAU PICT screening algorithm for children and adolescents and routine testing in pediatric wards, TB sector and maternal and childcare services for all children and adolescents • Allocate dedicated counselors to high-volume pediatric entry points to ensure screening, testing and referral of CLHIV • Support to pediatric ART optimization via site level mentorship and pediatric training cascade; work with MISAU to integrate new pediatric ART formulations as appropriate • Improve stock management of pediatric ART via pharmacy mentorship • Optimize and scale mentor mother strategy for CLHIV <5 • Support and monitor disclosure support for children, adolescents and their families	• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS/G2G cooperative agreements, if jointly agreed upon by GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding

	• Support expansion of support groups for children and adolescents and for their parent or caregivers • Ongoing implementation of OVC program pivot to reach more children and adolescents living with HIV • Implement clinician shift schedules in order to offer consultations accommodating school schedules • Implement pediatric package for advanced disease in central, provincial and district hospitals as allowed by global fund procurement	

Adolescent treatment	Same as Adult Treatment (see above) plus:
	• Support implementation of prevention activities in non-DREAMs districts
	  ○ Implement and expand the access to PrEP for adolescents at high risk > 15 years
	  ○ Support implementation of self-testing for adolescents and youth
	• Train and allocate dedicated age appropriate peer mentors for adolescents and youth at high-volume sites
	• Train and monitor implementation of dedicated teen mentor mothers
	• Support implementation of adolescents led group sessions
		• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique IP budgets but may be supported via MISAU or DPS/G2G cooperative agreements, if jointly agreed upon by GRM and PEPFAR Mozambique
		• Site-level HRH at central support sites will be determined by MISAU's COP20 funding

Additional Considerations for PMTCT/EID**	Same as Adult Treatment (see above) plus: • Expand implementation of MISAU mentor mother strategy by employing facility and community-based mentor mothers at all AJUDA sites	• IP support for EID sample transport • Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS/G2G cooperative agreements, if jointly agreed upon by GRM and PEPFAR Mozambique

	● In coordination with MISAU, implement tailored mentor mother package for teen PLW, using age appropriate mentor mothers ● Support PrEP for sero-discordant couples and AGYW ● Support implementation of revised psychosocial support and positive prevention tools tailored to support PLW as well as dissemination of new algorithms and job aids. ● Expand implementation of MISAU's national policy to integrate HIV services into mobile brigades to provide high quality primary care, ART access and PMTCT in remote communities in provinces with high VT. ● Implement retesting policy for breastfeeding women at 4- and 9-months prioritizing sites with higher VT and burden of new infant infections; expand program support based in alignment with RTK availability ● Support for EID POC and conventional EID PCR testing in alignment with national MISAU strategy ● Support implementation of point-of-care (POC) VL for PLW, prioritizing high positivity sites and provinces ● Continued support for one stop model for PMTCT within ANC/CCR services ● Continued support for Option B+ implementation using DTG based regimens, aligned with the MISAU DTG scale-up plan, ● Support integration of HIV/family planning (FP) and increasing access to FP methods	● Site-level HRH at central support sites will be determined by MISAU's COP20 funding

	among HIV-positive women of reproductive age following appropriate informed consent	
Cervical Cancer	• Increase screening and treatment access via support for CECAP HR, infrastructure and commodities. • Support training in visual inspection with acetic acid (VIA), cryotherapy, LEEP and criteria for referral for surgical management • In alignment with DPS/MISAU national cervical CA scale up plan, support procurement of CECAP equipment • Strengthen referral and counter-referral system for treatment of preclinical and clinical lesions and follow-up after treatment • Increase LEEP access and quality via expansion of LEEP enabled treatment sites and site level QA/supervision at centers receiving referral for LEEP • Support site level quality assurance for screening and treatment • Support TA for cervical CA program implementation including supervision/QA visits and capacity building at provincial, district and facility level • Conduct awareness-raising activities with community health workers to increase the uptake of screening and treatment for cervical pre-cancer and engage in community-based demand creation activities for CECAP • Ensure minor renovations as necessary to ensure adequate private space in reproductive health clinic for pelvic examinations/VIA/cryo at identified sites	• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS/G2G cooperative agreements, if jointly agreed upon by GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding

	• Support procurement of pathology reagents for biopsy and LEEP specimens • Support MISAU in relevant guideline and policy development at central level	
GBV	• Ensure that facility staff in ART/HTC/ANC/Auxiliary are sensitized to availability of GBV services and referral process to post-GBV care at HU • Establish post-GBV care services in all scale up ART sites and allocate the recommended post-rape kits; ensure GBV algorithms visible • Provide post-GBV care services as part of KP prevention package in all facilities that offer services for KPs • Reinforce demand creation to promote post-GBV services & PEP at community and facility levels	• Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding

TB/HIV***	• TPT-scale up: improve TB screening, identification and start treatment for Latent TB • Continuation of INH integration into 3MDD • Introduction of 3HP regimen for TPT • Defaulter tracing of patients who are "LTFU" without evidence of TPT completion • Implementation of FAST strategy, which includes ongoing support for cough officers • Active pharmacovigilance for INH and 3HP adverse events • Integrated TB/HIV community package: Community tracing for screening and testing of household contacts of co-infected index clients • Implement TB LAM at central facilities through HIV advanced disease package • Promote use/scale-up of district-based GeneXpert testing as the primary diagnostic test for all presumptive TB • In order to improve the clinical and laboratory management of TB patients, use existing electronic data entry clerks to support digitization of TB case records at PEPFAR facilities that have existing electronic TB information systems	• Sample transport for TB • Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding
Viral Load / Lab	• Provincial and site level lab support to optimize VL and TB results return and utilization • Support national laboratory testing quality assurance for VL/EID/TB • Support for decentralized EQA/PT program	• IP support for sample transport for VL • Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR Mozambique

	• Support decentralization of FOGELA program • Support expansion of laboratory information System (LIS)/ DISA-Link and DISA-POC for monitoring and optimizing VL and EID cascades • Support OpenLDR-OpenMRS/EPTS linkage and automated data transfer of VL results	• Site-level HRH at central support sites will be determined by MISAU's COP20 funding
M&E	• Support for routine M&E activities (data clerks, training, EPTS supervision and mentoring, participation in district data reviews) • Continued support for printing, reproduction and distribution of HIV instruments and forms • Routine data quality assurance and improvement activities (DQA, National Chart Cleaning, supervisory site visits, SIMS) for all quarterly indicators and enhanced monitoring of key interventions for retention • Data quality initiative including quarterly audits, with consequences for falsified data	• Quarterly reporting of HTS_TST, HTS_TST_POS, TX_CURR, TX_NEW, TX_PVLS, PMTCT_STAT, and PMTCT_ART via GRM reporting systems • Supervision and training for clinical staff at central support sites will not be included in PEPFAR Mozambique clinical IP budgets but may be supported via MISAU or DPS cooperative agreements, if jointly agreed upon by GRM and PEPFAR Mozambique • Site-level HRH at central support sites will be determined by MISAU's COP20 funding
Informatics (HMIS)	• Support for EPTS system modifications • Ongoing data quality review and resolution • Continue to implement pharmacy system scale up for drug management in collaboration with PEPFAR HMIS team (i.e., iDART) and continue to support pharmacy supply chain system (i.e., SIGLUS) • Continue implementation of linkage of external systems (i.e., pharmacy, laboratory, mhealth) with EPTS • Ensure alignment of HMIS systems with PEPFAR Mozambique requirements and MISAU M&E platforms	• N/A

Supply Chain	● Last mile medicines delivery through either IP or a centralized contract ● Last mile specimen transport through either IP or a centralized contract ● Viral load and EID conventional laboratory instrument provision, maintenance, repairs and reagent delivery to the labs ● Commodity support for ARVs (adult, pediatric, and PrEP), RTKs, viral load (conventional and select POC reagents and collection kits), EID (conventional and POC reagents and collection kits), VMMC, and TPT (3HP) ● SIGLUS implementation and support	● Last mile medicines delivery through either IP or a centralized contract ● Last mile specimen transport through either IP or a centralized contract ● Viral load and EID conventional laboratory instrument provision, maintenance, repairs and reagent delivery to the labs ● Commodity support for ARVs (adult, pediatric, and PrEP), RTKs, viral load (conventional and select POC reagents and collection kits), EID (conventional and POC reagents and collection kits), VMMC, and TPT (3HP)

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The PEPFAR Mozambique team, in collaboration with MISAU and other key stakeholders, reviewed Table 6 activities as part of COP20 planning. The COP20 Table 6 builds on the previous year's portfolio, and only proposed activities essential to and or contributing to achieving epidemic control. All activities include clear milestones that allow for comprehensive assessment and monitoring.

Overall the budget for Table 6 activities decreased significantly, from $28,473,864 in COP18 to $15,500,000 in COP20. Above site investments have been consistently reduced as a percentage of the overall budget, dropping from 7% of the COP19 budget, to 4% of the COP20 budget. Substantial reductions were achieved between COP18 and COP20 through elimination of support for specific program areas (i.e., pre-service training, system development, etc.), completion of planned activities, and consolidation. Cost reduction strategies were driven by aggressive identification of efficiencies, shifting (wherever possible) responsibility for implementation away from international partners to local and/or government implementers, increasing PEPFAR Mozambique staff provision of direct technical assistance, and minimizing development of new initiatives.

The above-site activities in COP20 squarely aim at providing client centered HIV care that the Mozambican program is committed to delivering. They provide critical support across key areas including health information systems, laboratory systems, and supply chain strengthening. A focus on efficiency (financial, programmatic and technical) informed the selection of activities in Table 6. The above-site investments align with key programmatic priorities, including DSD scale-up, quality improvement and TPT scale-up.

COP20 above site investments align with the key systems barriers identified in the SID, with the bulk of resources targeted at areas with red or yellow scores SID scores. These include Health Information System (27 percent of proposed investments), Laboratory (25 percent of proposed investments), Supply Chain (20 percent of proposed investments). Limited resources were allocated to strategic information (14 percent of proposed investments in COP19), Human Resources for Health (7 percent of proposed investments), and Institutional capacity building (7 percent of proposed investments).

This year's COP planning was marked by an excellent level of coordination with MISAU and other donors. Several planning meetings were held at technical and management levels, which allowed for engagement with key partners and aligning expectations. PEPFAR Mozambique investments are increasingly better aligned with Government strategies, policies and systems. Common standards and frameworks inform HIS investments, and PEPFAR Mozambique is supporting the rollout of the NUIC (Unique Civil Identification Number). PEPFAR Mozambique is strengthening the national community platform through the National AIDS commission and has also aligned its HRH and supply chain support with national strategies, namely the HR retention plan and the

pharmaceutical logistics strengthening plan. PEPFAR Mozambique has implemented the HRH pivot, and scaled back support for lay workers, and shifting this support to categories of staff with enhanced prospects for absorption in the government system (i.e., facility-based staff (medical technicians, nurses, psychologists, etc.). PEPFAR Mozambique has also aligned its HRH compensation scale to government salary scales.

The program is maintaining strategic investments in surveys, research and evaluation, which will all contribute to improving program efficiencies. The case base surveillance pilot will help improve quality improvement through an assessment of retention, quality and impact of programs. The HDSS Polana Canico project, using community-based surveillance platforms, will contribute to improved understanding of quality and efficiency of programs. Key Population size estimations will provide improved data that will increase the efficiency of programs focused on key populations.

All activities in Table 6 have SMART targets and timelines. The benchmarks are realistic and are routinely used for quarterly program monitoring. Benchmarks were reviewed and improved during the COP development process

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

The below contains a staffing profile of the five USG agencies comprising PEPFAR Mozambique and their current staffing status.

There are currently a total of 201 positions for PEPFAR Mozambique implementing agencies. Of these, 180 positions are filled (90%) and 21 positions are currently vacant (10%). From the vacancies, 16% are slated for US Direct Hires (USDH), 5% are slated for US Personal Services Contractor (USPSC) and 79% are slated for Host Country National (HCN) positions.

Currently, there are USG positions which are fully or partially funded by PEPFAR Mozambique. Of these positions, 190 positions (95%) are fully PEPFAR Funded and allocate 100 percent of their time to PEPFAR and 11 positions (5%) are partially PEPFAR-Funded positions.

Health and Human Services (HHS)/CDC

In COP20, CDC is requesting 3 new position to support the PEPFAR Mozambique portfolio: 2 Medical Officer Regional Advisors who will provide enhanced monitoring of Partner performance and strengthen collaboration at the DPS level; and 1 additional Cooperative Agreement Specialist to oversee G2G administrative and financial reporting. CDC has a total of 3 vacant positions all of which are Host Country National, 1 has been made an offer and 2 are pending classification for recruitment. All recruitment efforts will follow Embassy HR guidance for HCN positions.

Workspace and necessary equipment will be moved to the New Embassy Compound (NEC)in Maputo by August 2019.

United States Agency for International Development (USAID)
USAID has 81 PEPFAR-funded positions, including 70 fully funded and 11 that are partially PEPFAR-funded. USAID's current staffing footprint will allow the agency to meet SIMS requirements, and to monitor site-level program requirements. USAID does not propose any new positions for COP20.

For COP20, USAID completed a substantive review of PEPFAR Mozambique vacancies and the portfolio's programmatic and analytic needs. This analysis suggested that four vacant PEPFAR-funded positions should be repurposed to ensure the team has the required skill sets to fulfill COP20 requirements. Proposed repurposing is as follows: 1) Program Coordinator position (AAAS Fellow-USDH), to be repurposed to a Laboratory Support Systems Specialist (AAAS Fellow-USDH) to lead USAID's analysis, coordination, management and implementation of laboratory support services and initiatives, including optimization of the lab network; 2) Provincial Advisor (LES), to be repurposed to a Senior Commodities Supply and Information Specialist (LES) for commodity forecasting, quantification, supply planning, and data analysis, 3) Project Management Specialist (LES) to be repurposed to a Project Accountant (LES) to accommodate increasing demand for financial analysis, mentoring, and oversight of local partners, and 4) Janitor (LES) to be repurposed to Voucher Examiner (LES) to strengthen financial oversight of local awards.

USAID has 15 vacancies. Six of these vacancies are new positions being created during COP19 to support localization. All six positions have Chief of Mission authority to proceed with their creation and are in the process of recruitment. Four of the 15 vacancies finished recruitment, with the selected candidates awaiting clearances. Three of the 15 vacancies have been advertised, and one more position will be advertised in March 2020. The final vacant position, the aforementioned Senior Commodities Supply and Information Specialist, is in the process of being repurposed, as described above, and will be advertised during COP19 after all approvals have been obtained.

USAID proposes a COP20 Cost of Doing Business level that is flatlined from COP19.

Peace Corps
In COP 20, Peace Corps proposes no new positions. Peace Corps has a total of 20 fully PEPFAR-funded positions in COP 20, all of which are filled by HCNs, and one of which is a vacant position that will be filled within the next 2 months. Peace Corps COP20 staffing structure represents no change in comparison to COP19. In COP20, Peace Corps CODB is 4% less than in COP19. This is because we expect to receive less number of Peace Corps volunteers, which will then result in less volunteer cost.

Department of State
In COP20, State proposes 1 new PEPFAR Mozambique funded position (Deputy DREAMS Coordinator) to support the interagency DREAMS program. This position will provide backup to

the DREAMS coordinator and is being proposed as a result of the rapid expansion of the DREAM program (currently 9 districts vs proposed 32 districts) and staffing needed to support this expansion.

State has a total of 11 fully PEPFAR-funded positions at a 100 percent allocation, of which 9 HCNs, 1 is a PSA Eligible Family Member and 1 is a USDH. Of these 11 positions, 9 are filled and 2 are vacant, however, candidates have accepted offers from Post's Human Resource Office and are awaiting security clearance to begin working.

The staffing structure for State remains the same in COP20 as compared to COP19.

State is proposing a 14% CODB increase due to the hiring of the Deputy Dreams Coordinator position as well as staff program travel to the increased proposed number of districts. Also, during COP19, PCO will be able to fill all the vacant positions which will result in additional Capital Security Cost Sharing and Computers/IT services costs.

Department of Defense (DoD)
DOD has a total of 4 PEPFAR-funded positions. All 4 positions have been filled. DOD proposes a COP20 Cost of Doing Business level that is flatlined from COP19.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

SNU	Psnu	FY	Prioritization	<01		01-04		05-09		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-59		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Zambezia	Alto Molocue	FY18	Scale Up Agg	21%	20%	33%	49%	27%	41%	15%	29%	10%	23%	20%	47%	26%	54%	27%	46%	27%	38%	22%	28%	21%	23%	33%	26%
Zambezia	Alto Molocue	FY19	Scale Up Agg	24%	22%	36%	54%	30%	45%	16%	32%	11%	26%	22%	52%	28%	60%	30%	51%	30%	42%	24%	31%	23%	26%	37%	29%
Zambezia	Alto Molocue	FY20	Scale Up	33%	36%	56%	69%	48%	56%	32%	45%	20%	52%	46%	70%	47%	71%	47%	60%	48%	57%	41%	48%	38%	37%	48%	42%
Zambezia	Alto Molocue	FY21	Scale Up	46%	57%	85%	92%	73%	72%	56%	64%	34%	92%	83%	97%	73%	87%	73%	75%	74%	79%	65%	74%	61%	53%	64%	61%
Cabo Delgado	Ancuabe	FY18	Scale Up Agg	35%	26%	46%	53%	26%	47%	12%	20%	5%	36%	15%	45%	23%	44%	30%	51%	30%	42%	34%	39%	34%	29%	45%	40%
Cabo Delgado	Ancuabe	FY19	Sustained	42%	30%	55%	63%	31%	57%	14%	23%	6%	43%	19%	55%	28%	54%	37%	62%	37%	51%	42%	47%	42%	35%	55%	49%
Cabo Delgado	Ancuabe	FY20	Scale Up	53%	44%	92%	102%	53%	74%	29%	44%	14%	66%	30%	70%	37%	66%	49%	73%	47%	59%	51%	55%	49%	44%	60%	55%
Cabo Delgado	Ancuabe	FY21	Scale Up	77%	73%	163%	175%	94%	106%	58%	83%	31%	110%	51%	100%	56%	90%	74%	92%	67%	75%	68%	71%	62%	62%	70%	65%
Nampula	Angoche	FY18	Scale Up Agg	24%	32%	24%	31%	23%	24%	20%	31%	16%	29%	13%	30%	17%	31%	19%	29%	21%	25%	18%	19%	18%	18%	22%	14%
Nampula	Angoche	FY19	Scale Up Agg	28%	38%	28%	36%	27%	28%	24%	36%	18%	34%	15%	35%	20%	36%	22%	33%	24%	30%	21%	22%	21%	21%	26%	17%
Nampula	Angoche	FY20	Scale Up	39%	50%	47%	55%	41%	46%	39%	52%	31%	50%	30%	54%	39%	57%	37%	53%	41%	45%	32%	35%	35%	30%	44%	26%

Nampula	Angoche	FY21	Scale Up	59%	74%	80%	88%	65%	78%	65%	79%	53%	80%	57%	87%	73%	93%	64%	87%	70%	72%	53%	57%	59%	46%	76%	43%
Tete	Angonia	FY18	Sustained	0%	0%	36%	21%	23%	20%	14%	23%	12%	18%	25%	57%	31%	54%	38%	61%	44%	55%	41%	41%	30%	28%	34%	32%
Tete	Angonia	FY19	Sustained	0%	0%	36%	21%	23%	20%	14%	23%	13%	18%	25%	57%	31%	54%	38%	61%	43%	55%	41%	41%	30%	28%	34%	32%
Tete	Angonia	FY20	Scale Up	50%		65%	53%	56%	54%	30%	40%	32%	40%	40%	61%	46%	54%	48%	61%	57%	63%	52%	52%	40%	38%	44%	41%
Tete	Angonia	FY21	Scale Up	78%		119%	113%	118%	120%	56%	69%	65%	72%	65%	65%	68%	61%	65%	74%	85%	77%	75%	75%	62%	57%	62%	57%
Cabo Delgado	Balama	FY18	Sustained	20%	0%	46%	45%	15%	14%	6%	18%	8%	35%	17%	52%	21%	48%	24%	37%	28%	27%	22%	28%	16%	14%	25%	16%
Cabo Delgado	Balama	FY19	Sustained	31%	0%	70%	68%	23%	22%	9%	28%	13%	54%	25%	78%	32%	72%	37%	55%	42%	41%	33%	43%	24%	21%	38%	24%
Cabo Delgado	Balama	FY20	Scale Up	44%	20%	95%	101%	47%	52%	25%	47%	21%	72%	35%	86%	41%	80%	49%	67%	52%	51%	43%	51%	33%	33%	45%	32%
Cabo Delgado	Balama	FY21	Scale Up	69%	62%	143%	166%	93%	110%	55%	83%	37%	108%	55%	100%	59%	94%	74%	91%	70%	70%	64%	69%	51%	54%	58%	48%
Manica	Barue	FY18	Scale Up Sat	4%	9%	37%	69%	33%	37%	14%	23%	14%	30%	15%	60%	26%	67%	41%	57%	37%	49%	35%	42%	36%	32%	46%	40%
Manica	Barue	FY19	Scale Up Agg	4%	11%	38%	70%	33%	38%	14%	24%	14%	30%	15%	61%	27%	68%	42%	58%	37%	49%	36%	42%	37%	33%	46%	41%
Manica	Barue	FY20	Scale Up	37%	43%	67%	87%	57%	62%	33%	41%	31%	46%	32%	70%	41%	74%	53%	65%	49%	58%	46%	51%	45%	42%	53%	48%
Manica	Barue	FY21	Scale Up	111%	118%	133%	124%	113%	117%	77%	80%	70%	80%	70%	93%	72%	88%	77%	83%	76%	79%	70%	72%	62%	61%	69%	62%

Sofala	Beira	FY18	Scale Up Agg	27%	22%	49%	49%	54%	65%	47%	50%	31%	27%	19%	46%	19%	45%	28%	50%	31%	46%	31%	43%	32%	34%	48%	38%
Sofala	Beira	FY19	Scale Up Agg	24%	20%	46%	45%	50%	60%	43%	46%	29%	25%	17%	42%	17%	42%	25%	46%	29%	42%	29%	39%	30%	31%	44%	35%
Sofala	Beira	FY20	Scale Up	45%	43%	66%	66%	68%	76%	58%	60%	47%	41%	36%	54%	33%	52%	39%	55%	42%	53%	41%	50%	39%	42%	51%	46%
Sofala	Beira	FY21	Scale Up	86%	86%	108%	111%	108%	112%	89%	90%	87%	73%	75%	76%	66%	72%	68%	74%	72%	77%	69%	75%	61%	67%	68%	71%
Gaza	Bilene	FY18	Scale Up Agg	36%	43%	71%	82%	84%	98%	57%	60%	25%	52%	20%	79%	35%	77%	45%	82%	45%	76%	39%	66%	34%	55%	89%	87%
Gaza	Bilene	FY19	Scale Up Agg	39%	43%	75%	86%	88%	102%	60%	63%	26%	55%	21%	83%	36%	80%	47%	86%	47%	80%	41%	69%	36%	58%	93%	91%
Gaza	Bilene	FY20	Scale Up	59%	63%	108%	109%	91%	102%	61%	64%	40%	64%	38%	96%	52%	88%	61%	87%	58%	80%	53%	70%	43%	59%	94%	92%
Gaza	Bilene	FY21	Scale Up	89%	93%	158%	147%	93%	102%	65%	67%	64%	78%	65%	117%	79%	100%	84%	88%	78%	81%	73%	72%	56%	61%	97%	95%
Maputo	Boane	FY18	Scale Up Agg	20%	23%	25%	24%	29%	27%	35%	42%	25%	26%	10%	34%	13%	35%	20%	44%	24%	46%	25%	41%	23%	35%	39%	50%
Maputo	Boane	FY19	Scale Up Agg	21%	25%	27%	26%	31%	29%	37%	45%	26%	28%	11%	37%	14%	38%	22%	47%	25%	49%	26%	44%	25%	37%	42%	53%
Maputo	Boane	FY20	Scale Up	26%	30%	32%	33%	35%	34%	43%	52%	46%	45%	21%	48%	22%	48%	35%	53%	38%	53%	41%	50%	35%	42%	48%	55%
Maputo	Boane	FY21	Scale Up	39%	43%	45%	48%	45%	46%	58%	67%	92%	87%	44%	75%	43%	72%	68%	66%	67%	65%	76%	65%	59%	54%	61%	59%
Sofala	Buzi	FY18	Scale Up Agg	14%	23%	48%	27%	40%	69%	21%	37%	15%	20%	13%	51%	36%	60%	36%	63%	35%	43%	34%	35%	25%	23%	29%	22%

Sofala	Buzi	FY19	Scale Up Agg	12%	22%	45%	25%	38%	65%	20%	35%	14%	19%	12%	48%	34%	57%	34%	59%	33%	40%	32%	32%	23%	21%	27%	21%
Sofala	Buzi	FY20	Scale Up	37%	45%	65%	54%	61%	79%	40%	52%	36%	36%	32%	58%	46%	64%	46%	66%	46%	52%	44%	45%	34%	34%	37%	35%
Sofala	Buzi	FY21	Scale Up	84%	88%	108%	116%	110%	110%	85%	88%	84%	71%	74%	78%	73%	79%	71%	81%	74%	76%	70%	72%	57%	62%	58%	65%
Tete	Cahora Bassa	FY18	Sustained	18%	8%	35%	66%	57%	59%	37%	34%	40%	65%	36%	128%	66%	110%	84%	122%	83%	75%	50%	48%	42%	32%	42%	31%
Tete	Cahora Bassa	FY19	Sustained	15%	8%	35%	66%	58%	59%	37%	34%	41%	66%	37%	129%	67%	111%	85%	123%	83%	75%	50%	49%	43%	32%	43%	31%
Tete	Cahora Bassa	FY20	Scale Up	58%	63%	64%	80%	76%	77%	48%	49%	54%	75%	49%	129%	74%	111%	87%	123%	87%	80%	60%	58%	51%	42%	51%	41%
Tete	Cahora Bassa	FY21	Scale Up	77%	92%	119%	106%	109%	110%	67%	73%	76%	88%	70%	129%	84%	111%	92%	123%	96%	88%	78%	78%	69%	59%	67%	56%
Sofala	Caia	FY18	Scale Up Agg	52%	50%	61%	58%	22%	31%	19%	31%	16%	30%	18%	44%	28%	52%	33%	57%	30%	54%	27%	40%	27%	27%	35%	34%
Sofala	Caia	FY19	Attained	57%	53%	65%	61%	23%	32%	20%	33%	17%	32%	19%	46%	30%	56%	35%	61%	32%	58%	29%	42%	29%	29%	37%	36%
Sofala	Caia	FY20	Scale Up	69%	67%	78%	76%	51%	60%	40%	50%	38%	47%	37%	57%	43%	63%	47%	68%	45%	66%	41%	53%	39%	40%	45%	47%
Sofala	Caia	FY21	Scale Up	91%	91%	105%	108%	113%	120%	85%	88%	84%	76%	76%	78%	71%	79%	72%	81%	73%	83%	69%	76%	61%	65%	64%	72%
Tete	Changara	FY18	Scale Up Sat	24%	24%	68%	66%	69%	81%	32%	36%	22%	68%	53%	135%	93%	163%	110%	132%	100%	95%	67%	62%	56%	38%	44%	49%
Tete	Changara	FY19	Scale Up Agg	27%	27%	67%	66%	69%	80%	31%	36%	22%	67%	52%	135%	92%	163%	110%	131%	100%	94%	66%	61%	56%	38%	43%	48%

Tete	Changara	FY20	Scale Up	64%	71%	82%	80%	82%	89%	44%	50%	39%	76%	62%	135%	94%	163%	110%	131%	100%	95%	73%	69%	63%	47%	52%	55%
Tete	Changara	FY21	Scale Up	82%	91%	110%	106%	107%	105%	64%	74%	68%	89%	77%	135%	96%	163%	110%	131%	100%	97%	86%	84%	76%	63%	67%	67%
Sofala	Chemba	FY18	Sustained	12%	15%	26%	30%	21%	24%	13%	16%	11%	22%	15%	34%	24%	38%	33%	42%	37%	38%	31%	31%	27%	26%	40%	32%
Sofala	Chemba	FY19	Sustained	64%	82%	19%	28%	13%	19%	14%	18%	11%	79%	25%	100%	57%	59%	54%	64%	60%	72%	9%	8%	11%	11%	10%	8%
Sofala	Chemba	FY20	Central Support	74%	87%	49%	56%	45%	52%	36%	39%	34%	84%	42%	100%	65%	66%	62%	70%	68%	78%	25%	25%	23%	25%	21%	24%
Sofala	Chemba	FY21	Central Support	91%	100%	114%	114%	115%	123%	84%	86%	83%	92%	77%	100%	82%	80%	80%	83%	85%	89%	60%	62%	51%	57%	48%	59%
Sofala	Cherin-goma	FY18	Attained	0%	12%	31%	82%	30%	57%	21%	10%	12%	32%	10%	57%	16%	55%	30%	63%	28%	42%	15%	29%	19%	19%	25%	31%
Sofala	Cherin-goma	FY19	Sustained	0%	9%	29%	78%	28%	54%	19%	10%	11%	30%	9%	54%	15%	52%	28%	60%	26%	40%	15%	28%	18%	18%	24%	29%
Sofala	Cherin-goma	FY20	Scale Up	28%	36%	55%	87%	55%	73%	39%	33%	33%	45%	30%	63%	31%	60%	41%	67%	40%	51%	29%	41%	29%	31%	34%	41%
Sofala	Cherin-goma	FY21	Scale Up	82%	82%	111%	105%	112%	113%	84%	84%	82%	75%	72%	81%	65%	77%	69%	81%	71%	76%	62%	70%	55%	60%	57%	69%
Sofala	Chibabava	FY18	Scale Up Agg	12%	15%	34%	36%	39%	54%	28%	26%	13%	29%	12%	46%	31%	56%	39%	66%	38%	56%	33%	40%	30%	25%	30%	21%
Sofala	Chibabava	FY19	Scale Up Sat	14%	17%	36%	39%	43%	58%	31%	28%	14%	32%	13%	51%	34%	62%	42%	72%	41%	61%	36%	44%	33%	28%	33%	22%
Sofala	Chibabava	FY20	Scale Up	38%	41%	60%	63%	64%	76%	49%	47%	36%	47%	32%	61%	46%	68%	53%	77%	52%	69%	47%	54%	42%	39%	41%	36%

Sofala	Chibabava	FY21	Scale Up	83%	86%	110%	113%	110%	112%	87%	87%	84%	76%	74%	80%	73%	82%	75%	87%	77%	84%	72%	77%	63%	65%	62%	66%
Gaza	Chibuto	FY18	Scale Up Sat	34%	35%	87%	104%	106%	118%	64%	73%	41%	59%	23%	74%	35%	69%	54%	77%	63%	83%	57%	74%	46%	56%	134%	88%
Gaza	Chibuto	FY19	Scale Up Sat	38%	39%	90%	108%	111%	123%	66%	77%	43%	61%	24%	77%	36%	72%	56%	80%	65%	86%	59%	76%	48%	58%	139%	91%
Gaza	Chibuto	FY20	Scale Up	58%	60%	103%	108%	111%	123%	68%	77%	53%	69%	40%	95%	52%	83%	67%	81%	73%	86%	68%	77%	54%	59%	139%	92%
Gaza	Chibuto	FY21	Scale Up	91%	90%	123%	108%	111%	123%	71%	79%	72%	82%	66%	123%	79%	100%	87%	84%	86%	87%	82%	79%	64%	61%	139%	95%
Gaza	Chicuala-cuala	FY18	Scale Up Sat	0%	0%	98%	60%	61%	66%	38%	55%	30%	30%	14%	64%	18%	108%	26%	71%	35%	122%	38%	110%	43%	106%	102%	184%
Gaza	Chicuala-cuala	FY19	Scale Up Agg	0%	0%	137%	84%	82%	90%	52%	73%	33%	32%	14%	68%	20%	116%	28%	76%	38%	131%	41%	119%	46%	114%	109%	198%
Gaza	Chicuala-cuala	FY20	Central Support	33%	34%	137%	110%	86%	94%	54%	74%	45%	45%	32%	93%	40%	116%	47%	78%	51%	131%	53%	119%	52%	114%	109%	198%
Gaza	Chicuala-cuala	FY21	Central Support	75%	75%	137%	153%	89%	103%	59%	76%	67%	68%	63%	131%	73%	116%	79%	81%	74%	131%	73%	119%	63%	114%	109%	198%
Tete	Chifunde	FY18	Attained	32%	39%	52%	58%	32%	37%	16%	19%	14%	45%	31%	88%	51%	89%	60%	86%	51%	68%	36%	49%	27%	35%	32%	52%
Tete	Chifunde	FY19	Sustained	175%	275%	39%	61%	21%	32%	15%	24%	136%	163%	109%	96%	78%	71%	64%	68%	53%	66%	45%	62%	47%	72%	31%	65%
Tete	Chifunde	FY20	Central Support	175%	275%	66%	77%	54%	61%	30%	41%	136%	163%	109%	96%	83%	71%	69%	68%	64%	72%	55%	69%	55%	76%	41%	70%

Tete	Chifunde	FY21	Central Support	175%	275%	117%	106%	118%	118%	55%	70%	136%	163%	109%	97%	89%	75%	79%	79%	87%	83%	76%	84%	70%	83%	60%	78%
Gaza	Chigubo	FY18	Sustained	86%	0%	100%	116%	60%	106%	64%	46%	33%	37%	16%	85%	16%	104%	33%	86%	46%	87%	45%	110%	34%	71%	113%	143%
Gaza	Chigubo	FY19	Sustained	133%	0%	144%	169%	87%	153%	92%	66%	38%	42%	19%	95%	18%	117%	37%	96%	51%	97%	50%	124%	39%	80%	127%	161%
Gaza	Chigubo	FY20	Central Support	133%	34%	144%	169%	91%	153%	92%	66%	49%	54%	36%	99%	38%	117%	54%	96%	62%	97%	60%	124%	46%	80%	127%	161%
Gaza	Chigubo	FY21	Central Support	133%	100%	144%	169%	94%	153%	92%	69%	69%	72%	65%	105%	73%	117%	81%	96%	80%	97%	77%	124%	58%	81%	127%	161%
Niassa	Chimbon-ila	FY18	Sustained	11%	13%	20%	23%	18%	22%	14%	17%	11%	19%	12%	28%	15%	33%	19%	38%	22%	37%	21%	34%	19%	28%	25%	38%
Niassa	Chimbon-ila	FY19	Central Support	40%	70%	5%	18%	4%	10%	4%	16%	33%	24%	17%	45%	29%	28%	27%	32%	30%	38%	33%	46%	41%	63%	30%	51%
Niassa	Chimbon-ila	FY20	Central Support	69%	82%	42%	52%	40%	45%	33%	42%	50%	42%	34%	57%	42%	41%	40%	45%	44%	52%	46%	58%	51%	70%	42%	59%
Niassa	Chimbon-ila	FY21	Central Support	100%	100%	113%	118%	112%	114%	84%	89%	80%	74%	64%	76%	62%	65%	62%	70%	69%	77%	71%	80%	71%	83%	63%	74%
Manica	Chimoio	FY18	Scale Up Agg	21%	51%	65%	69%	58%	65%	41%	50%	27%	43%	20%	65%	28%	68%	38%	74%	42%	64%	40%	51%	36%	40%	59%	51%
Manica	Chimoio	FY19	Scale Up Sat	20%	52%	64%	69%	57%	64%	41%	50%	26%	43%	19%	65%	28%	68%	38%	73%	41%	64%	39%	50%	35%	40%	58%	50%
Manica	Chimoio	FY20	Attained	48%	69%	81%	86%	73%	78%	54%	61%	41%	55%	35%	74%	42%	74%	49%	78%	52%	70%	49%	58%	43%	48%	63%	56%

Manica	Chimoio	FY21	Scale Up	109%	109%	119%	125%	108%	110%	84%	87%	74%	84%	72%	94%	72%	88%	75%	89%	78%	85%	72%	76%	61%	65%	75%	68%
Zambezia	Chinde	FY18	Scale Up Agg	8%	16%	52%	93%	40%	62%	19%	16%	4%	30%	19%	48%	25%	50%	32%	56%	25%	39%	26%	33%	19%	19%	29%	25%
Zambezia	Chinde	FY19	Scale Up Agg	6%	12%	39%	70%	30%	47%	15%	12%	3%	23%	14%	36%	19%	38%	24%	42%	19%	29%	20%	25%	14%	15%	22%	19%
Zambezia	Chinde	FY20	Central Support	17%	28%	58%	80%	48%	57%	31%	28%	13%	50%	41%	60%	40%	55%	43%	53%	40%	47%	38%	44%	31%	28%	35%	33%
Zambezia	Chinde	FY21	Central Support	33%	53%	86%	95%	73%	73%	55%	53%	28%	92%	81%	96%	70%	80%	70%	70%	70%	74%	63%	71%	56%	46%	55%	56%
Cabo Delgado	Chiure	FY18	Scale Up Sat	21%	28%	48%	56%	39%	47%	19%	21%	9%	36%	20%	47%	28%	49%	37%	54%	39%	50%	39%	41%	46%	33%	55%	40%
Cabo Delgado	Chiure	FY19	Scale Up Agg	27%	33%	59%	69%	49%	58%	23%	25%	11%	44%	25%	58%	34%	61%	46%	67%	49%	61%	48%	51%	57%	40%	67%	49%
Cabo Delgado	Chiure	FY20	Scale Up	41%	47%	93%	101%	65%	74%	36%	45%	20%	67%	35%	73%	43%	71%	57%	76%	57%	68%	56%	59%	62%	49%	71%	54%
Cabo Delgado	Chiure	FY21	Scale Up	69%	73%	157%	163%	96%	106%	62%	83%	35%	110%	55%	100%	60%	92%	78%	93%	73%	80%	72%	73%	72%	65%	78%	65%
Tete	Chiuta	FY18	Sustained	0%	0%	7%	53%	37%	38%	35%	21%	23%	67%	70%	136%	78%	109%	60%	84%	72%	77%	60%	48%	25%	28%	40%	28%
Tete	Chiuta	FY19	Attained	0%	0%	10%	62%	41%	42%	39%	25%	27%	77%	78%	154%	88%	123%	68%	95%	82%	87%	68%	54%	28%	32%	45%	32%
Tete	Chiuta	FY20	Scale Up			50%	78%	66%	67%	50%	41%	43%	83%	82%	154%	90%	123%	73%	95%	86%	89%	74%	63%	39%	41%	53%	41%
Tete	Chiuta	FY21	Scale Up			129%	105%	113%	113%	69%	70%	71%	92%	90%	154%	94%	123%	82%	97%	95%	94%	87%	81%	60%	59%	68%	57%

Gaza	Chokwe	FY18	Scale Up Sat	50%	78%	90%	106%	111%	98%	55%	58%	28%	54%	24%	112%	38%	109%	51%	113%	54%	101%	47%	86%	40%	66%	100%	102%
Gaza	Chokwe	FY19	Scale Up Sat	52%	86%	102%	120%	126%	112%	62%	65%	28%	53%	23%	111%	38%	107%	51%	111%	53%	100%	46%	85%	39%	65%	99%	100%
Gaza	Chokwe	FY20	Scale Up	68%	91%	102%	120%	126%	112%	64%	66%	41%	62%	39%	111%	53%	107%	64%	111%	63%	100%	57%	85%	46%	66%	99%	100%
Gaza	Chokwe	FY21	Scale Up	93%	98%	102%	120%	126%	112%	67%	69%	65%	78%	66%	111%	79%	107%	86%	111%	81%	100%	75%	86%	59%	68%	99%	100%
Gaza	Chongu-ene	FY18	Scale Up Agg	47%	65%	79%	110%	109%	115%	69%	90%	28%	45%	16%	75%	29%	80%	44%	86%	44%	86%	36%	76%	34%	65%	92%	98%
Gaza	Chongu-ene	FY19	Scale Up Agg	50%	69%	86%	118%	117%	124%	74%	97%	31%	48%	18%	80%	31%	87%	48%	93%	48%	92%	39%	82%	37%	70%	99%	106%
Gaza	Chongu-ene	FY20	Scale Up	67%	80%	104%	118%	117%	124%	75%	97%	44%	58%	35%	96%	48%	92%	61%	94%	59%	93%	51%	82%	44%	71%	99%	106%
Gaza	Chongu-ene	FY21	Scale Up	94%	94%	134%	118%	117%	124%	77%	97%	66%	75%	64%	119%	77%	100%	85%	95%	79%	93%	72%	83%	57%	73%	99%	106%
Niassa	Cuamba	FY18	Scale Up Agg	17%	28%	43%	57%	41%	33%	36%	47%	22%	30%	16%	57%	19%	61%	33%	63%	50%	58%	35%	50%	48%	44%	50%	40%
Niassa	Cuamba	FY19	Scale Up Agg	17%	31%	45%	59%	43%	35%	38%	49%	24%	31%	16%	59%	19%	63%	35%	65%	52%	60%	37%	52%	50%	46%	52%	41%
Niassa	Cuamba	FY20	Scale Up	57%	59%	66%	76%	64%	60%	56%	64%	43%	47%	33%	68%	34%	70%	46%	72%	62%	69%	49%	62%	58%	56%	60%	52%
Niassa	Cuamba	FY21	Scale Up	100%	92%	107%	109%	107%	110%	90%	93%	79%	76%	64%	82%	58%	82%	66%	85%	79%	85%	73%	82%	75%	75%	75%	69%
Zambezia	Derre	FY18	Scale Up Agg	23%	0%	24%	26%	13%	12%	2%	3%	0%	23%	19%	37%	13%	30%	19%	22%	13%	21%	11%	17%	15%	10%	13%	9%

Zambezia	Derre	FY19	new	18%	0%	19%	21%	10%	9%	1%	3%	0%	18%	15%	29%	10%	24%	15%	17%	10%	16%	8%	13%	11%	8%	10%	7%
Zambezia	Derre	FY20	Scale Up	27%	19%	44%	48%	33%	28%	20%	21%	11%	47%	42%	56%	33%	45%	36%	34%	33%	38%	29%	35%	29%	22%	26%	24%
Zambezia	Derre	FY21	Scale Up	41%	47%	81%	86%	66%	55%	49%	49%	26%	91%	81%	96%	67%	75%	67%	57%	67%	69%	58%	67%	54%	42%	48%	50%
Tete	Doa	FY18	Sustained	0%	0%	24%	8%	17%	67%	6%	23%	17%	46%	15%	50%	66%	87%	80%	67%	55%	81%	37%	41%	21%	22%	32%	29%
Tete	Doa	FY19	new	0%	0%	29%	12%	19%	77%	7%	26%	19%	52%	16%	57%	74%	98%	91%	76%	62%	91%	42%	46%	24%	25%	36%	33%
Tete	Doa	FY20	Central Support			61%	48%	53%	87%	24%	42%	37%	65%	33%	61%	80%	98%	93%	76%	71%	93%	53%	56%	35%	35%	46%	42%
Tete	Doa	FY21	Central Support			124%	112%	119%	106%	52%	70%	69%	83%	61%	65%	87%	98%	95%	85%	89%	96%	75%	77%	59%	55%	63%	57%
Sofala	Dondo	FY18	Scale Up Sat	22%	50%	50%	79%	60%	66%	42%	38%	18%	32%	22%	58%	27%	65%	36%	68%	34%	53%	30%	48%	30%	35%	43%	40%
Sofala	Dondo	FY19	Scale Up Agg	19%	45%	45%	71%	54%	59%	38%	34%	17%	29%	19%	52%	25%	59%	33%	61%	31%	48%	27%	43%	27%	31%	39%	36%
Sofala	Dondo	FY20	Scale Up	42%	61%	65%	82%	71%	76%	54%	52%	38%	44%	37%	62%	39%	66%	45%	68%	44%	58%	40%	53%	37%	42%	47%	47%
Sofala	Dondo	FY21	Scale Up	85%	90%	109%	106%	108%	112%	88%	88%	84%	74%	76%	80%	69%	80%	71%	81%	73%	79%	68%	77%	59%	67%	65%	72%
Nampula	Erati	FY18	Sustained	28%	22%	40%	35%	24%	29%	12%	27%	15%	41%	25%	56%	28%	55%	33%	56%	35%	41%	27%	29%	28%	20%	23%	15%
Nampula	Erati	FY19	Sustained	30%	23%	42%	36%	25%	31%	13%	28%	16%	43%	26%	59%	30%	57%	35%	59%	37%	43%	29%	30%	30%	21%	24%	16%

Nampula	Erati	FY20	Scale Up	41%	38%	57%	55%	39%	48%	29%	46%	29%	57%	39%	71%	47%	71%	47%	71%	51%	56%	39%	41%	42%	30%	43%	25%
Nampula	Erati	FY21	Scale Up	61%	66%	84%	88%	64%	79%	60%	77%	52%	82%	63%	92%	76%	95%	69%	92%	75%	78%	58%	61%	64%	46%	75%	43%
Inhambane	Funhal-ouro	FY18	Sustained	73%	37%	80%	158%	114%	76%	94%	68%	35%	55%	0%	44%	26%	57%	24%	68%	29%	90%	28%	82%	37%	72%	115%	143%
Inhambane	Funhal-ouro	FY19	Sustained	80%	40%	91%	183%	131%	87%	107%	78%	38%	58%	0%	47%	27%	60%	26%	72%	31%	96%	29%	87%	40%	76%	122%	152%
Inhambane	Funhal-ouro	FY20	Scale Up	83%	55%	97%	183%	131%	88%	107%	78%	53%	73%	24%	65%	43%	71%	44%	76%	50%	96%	47%	87%	47%	77%	122%	152%
Inhambane	Funhal-ouro	FY21	Scale Up	80%	80%	104%	183%	131%	90%	107%	85%	77%	96%	59%	92%	67%	86%	73%	82%	78%	96%	73%	87%	59%	78%	122%	152%
Zambezia	Gile	FY18	Scale Up Agg	74%	59%	73%	76%	30%	38%	12%	27%	12%	56%	41%	75%	37%	63%	32%	53%	35%	39%	26%	33%	21%	25%	33%	33%
Zambezia	Gile	FY19	Scale Up Agg	81%	63%	79%	82%	32%	41%	13%	30%	13%	61%	45%	81%	40%	68%	35%	58%	39%	42%	29%	36%	23%	27%	36%	36%
Zambezia	Gile	FY20	Scale Up	83%	70%	85%	88%	49%	53%	30%	43%	23%	75%	62%	88%	55%	77%	51%	66%	54%	57%	44%	52%	38%	38%	47%	47%
Zambezia	Gile	FY21	Scale Up	86%	80%	95%	97%	74%	71%	55%	63%	36%	96%	88%	99%	78%	90%	74%	78%	78%	79%	67%	76%	60%	54%	63%	65%
Manica	Gondola	FY18	Scale Up Agg	26%	45%	75%	90%	56%	66%	24%	36%	18%	49%	24%	88%	52%	103%	55%	81%	51%	64%	40%	50%	35%	36%	50%	43%
Manica	Gondola	FY19	Scale Up Agg	24%	44%	75%	90%	56%	66%	24%	36%	18%	49%	24%	88%	52%	103%	55%	81%	51%	65%	40%	50%	35%	36%	50%	43%
Manica	Gondola	FY20	Scale Up	50%	64%	87%	95%	72%	79%	41%	51%	34%	61%	39%	91%	62%	103%	63%	84%	60%	71%	50%	58%	43%	44%	56%	50%

Manica	Gondola	FY21	Scale Up	108%	112%	113%	108%	108%	109%	79%	83%	71%	86%	73%	98%	82%	103%	82%	92%	82%	86%	72%	76%	61%	63%	71%	64%
Sofala	Gorongosa	FY18	Sustained	5%	20%	25%	32%	25%	23%	21%	22%	11%	27%	12%	46%	23%	49%	34%	44%	34%	45%	26%	32%	23%	28%	33%	31%
Sofala	Gorongosa	FY19	Attained	4%	22%	26%	33%	26%	24%	22%	22%	11%	28%	13%	48%	23%	50%	35%	46%	35%	47%	27%	33%	24%	29%	34%	32%
Sofala	Gorongosa	FY20	Scale Up	30%	45%	53%	59%	53%	55%	42%	43%	34%	43%	32%	58%	38%	59%	47%	55%	48%	57%	39%	45%	34%	40%	43%	44%
Sofala	Gorongosa	FY21	Scale Up	81%	85%	112%	114%	112%	122%	85%	86%	83%	74%	74%	78%	69%	76%	72%	74%	75%	78%	68%	72%	58%	65%	62%	70%
Inhambane	Govuro	FY18	Scale Up Agg	0%	31%	61%	87%	102%	79%	81%	53%	75%	48%	29%	59%	19%	74%	35%	97%	51%	91%	46%	75%	53%	43%	115%	45%
Inhambane	Govuro	FY19	Sustained	0%	40%	87%	124%	147%	113%	117%	75%	88%	56%	33%	69%	22%	86%	40%	113%	59%	105%	53%	87%	61%	49%	133%	52%
Inhambane	Govuro	FY20	Scale Up	17%	55%	95%	124%	147%	113%	117%	76%	91%	72%	49%	79%	39%	90%	55%	113%	70%	105%	65%	87%	66%	50%	133%	59%
Inhambane	Govuro	FY21	Scale Up	50%	70%	109%	124%	147%	113%	117%	85%	96%	96%	73%	95%	65%	95%	78%	113%	87%	105%	82%	88%	73%	52%	133%	80%
Total	Grand Total	Total	Total	48%	55%	72%	78%	68%	75%	55%	62%	43%	63%	42%	76%	46%	74%	55%	76%	58%	74%	55%	66%	50%	53%	67%	65%
Gaza	Guija	FY18	Scale Up Sat	41%	53%	111%	105%	91%	120%	49%	45%	14%	44%	17%	85%	36%	91%	52%	104%	59%	101%	56%	86%	49%	62%	112%	99%
Gaza	Guija	FY19	Scale Up Agg	41%	53%	111%	106%	91%	120%	49%	46%	14%	44%	17%	86%	36%	92%	52%	104%	59%	102%	57%	86%	49%	62%	112%	99%
Gaza	Guija	FY20	Scale Up	61%	69%	111%	106%	93%	120%	51%	47%	30%	55%	34%	97%	52%	95%	64%	104%	68%	102%	65%	86%	55%	63%	112%	99%

Gaza	Guija	FY21	Scale Up	94%	94%	111%	106%	95%	120%	56%	52%	58%	74%	63%	114%	79%	100%	86%	104%	83%	102%	80%	87%	65%	65%	112%	100%
Manica	Guro	FY18	Sustained	0%	27%	80%	94%	68%	78%	49%	46%	13%	42%	36%	93%	54%	129%	55%	90%	60%	71%	55%	57%	49%	39%	65%	61%
Manica	Guro	FY19	Sustained	0%	27%	87%	102%	74%	85%	53%	50%	14%	46%	40%	102%	59%	141%	60%	99%	66%	78%	61%	62%	54%	42%	71%	66%
Manica	Guro	FY20	Scale Up		53%	93%	102%	84%	91%	63%	61%	31%	58%	52%	102%	67%	141%	68%	99%	72%	81%	67%	68%	60%	50%	75%	70%
Manica	Guro	FY21	Scale Up		118%	107%	102%	104%	105%	88%	87%	70%	84%	78%	102%	84%	141%	84%	99%	87%	91%	82%	82%	72%	67%	83%	79%
Zambezia	Gurue	FY18	Scale Up Agg	9%	23%	19%	33%	21%	24%	21%	23%	16%	27%	24%	43%	27%	46%	28%	49%	27%	39%	23%	37%	21%	27%	33%	27%
Zambezia	Gurue	FY19	Sustained	12%	29%	24%	42%	26%	30%	27%	29%	20%	32%	29%	52%	33%	56%	34%	59%	32%	47%	28%	44%	26%	33%	40%	32%
Zambezia	Gurue	FY20	Scale Up	23%	43%	47%	62%	45%	44%	41%	42%	28%	57%	51%	70%	50%	68%	50%	67%	50%	60%	44%	58%	41%	43%	50%	45%
Zambezia	Gurue	FY21	Scale Up	39%	60%	82%	90%	72%	65%	62%	62%	40%	93%	84%	97%	75%	86%	74%	79%	75%	80%	67%	79%	62%	58%	65%	63%
Inhambane	Homoine	FY18	Scale Up Agg	15%	58%	56%	74%	79%	101%	40%	92%	20%	44%	5%	42%	12%	40%	14%	66%	28%	78%	24%	91%	35%	77%	92%	148%
Inhambane	Homoine	FY19	Sustained	20%	70%	64%	84%	90%	117%	45%	106%	19%	45%	4%	42%	12%	41%	14%	67%	28%	79%	24%	92%	35%	77%	92%	149%
Inhambane	Homoine	FY20	Scale Up	33%	77%	87%	94%	92%	117%	46%	106%	39%	65%	27%	62%	31%	57%	36%	72%	48%	79%	43%	92%	44%	77%	93%	149%
Inhambane	Homoine	FY21	Scale Up	60%	90%	122%	107%	93%	117%	49%	106%	68%	95%	62%	91%	61%	80%	68%	79%	77%	80%	72%	92%	56%	79%	95%	149%

Cabo Delgado	Ibo	FY18	Sustained	0%	0%	68%	172%	0%	57%	0%	29%	0%	7%	17%	48%	30%	26%	18%	21%	10%	19%	9%	29%	7%	41%	62%	32%
Cabo Delgado	Ibo	FY19	Sustained	0%	0%	80%	200%	0%	67%	0%	33%	0%	8%	16%	47%	29%	25%	18%	21%	10%	18%	8%	29%	9%	41%	60%	31%
Cabo Delgado	Ibo	FY20	Central Support	20%	20%	96%	200%	31%	80%	17%	51%	9%	45%	28%	65%	39%	45%	34%	42%	25%	32%	22%	40%	20%	50%	64%	39%
Cabo Delgado	Ibo	FY21	Central Support	100%	100%	120%	200%	100%	100%	50%	83%	30%	116%	48%	100%	57%	85%	67%	83%	54%	58%	49%	62%	39%	66%	72%	52%
Zambezia	Ile	FY18	Scale Up Agg	29%	47%	44%	48%	26%	31%	9%	18%	7%	25%	21%	50%	25%	46%	31%	46%	29%	40%	24%	27%	23%	22%	23%	18%
Zambezia	Ile	FY19	Sustained	31%	49%	47%	50%	28%	33%	9%	19%	7%	26%	22%	52%	26%	48%	32%	49%	31%	42%	25%	28%	24%	23%	24%	19%
Zambezia	Ile	FY20	Scale Up	39%	58%	63%	67%	46%	46%	27%	34%	17%	53%	46%	70%	45%	62%	49%	59%	49%	57%	41%	46%	39%	35%	37%	33%
Zambezia	Ile	FY21	Scale Up	50%	71%	87%	92%	72%	66%	53%	57%	31%	92%	82%	97%	73%	83%	73%	74%	75%	78%	66%	73%	61%	52%	56%	56%
Nampula	Ilha De Moçambique	FY18	Sustained	38%	0%	50%	103%	66%	81%	48%	48%	19%	37%	18%	45%	19%	57%	36%	72%	34%	64%	40%	56%	47%	51%	54%	33%
Nampula	Ilha De Moçambique	FY19	Sustained	33%	0%	43%	90%	57%	70%	42%	42%	17%	32%	16%	39%	17%	49%	31%	63%	29%	56%	35%	49%	41%	44%	47%	29%
Nampula	Ilha De Moçambique	FY20	Scale Up	44%	20%	58%	93%	65%	78%	53%	56%	29%	49%	31%	57%	37%	66%	44%	74%	45%	65%	44%	57%	51%	51%	60%	37%
Nampula	Ilha De Moçambique	FY21	Scale Up	67%	56%	83%	97%	79%	93%	74%	79%	52%	80%	58%	88%	72%	94%	68%	93%	72%	83%	61%	72%	69%	62%	82%	52%

Inhambane	Inhambane	FY18	Scale Up Agg	38%	27%	62%	70%	68%	104%	74%	96%	44%	42%	14%	31%	12%	40%	19%	56%	25%	69%	22%	69%	38%	71%	103%	132%
Inhambane	Inhambane	FY19	Sustained	45%	36%	69%	77%	75%	116%	81%	106%	47%	45%	15%	33%	13%	42%	21%	59%	27%	73%	24%	73%	40%	75%	109%	140%
Inhambane	Inhambane	FY20	Scale Up	55%	52%	89%	91%	81%	116%	82%	106%	60%	65%	35%	56%	32%	58%	41%	65%	47%	73%	43%	74%	47%	75%	109%	140%
Inhambane	Inhambane	FY21	Scale Up	73%	73%	119%	111%	82%	116%	83%	106%	78%	95%	66%	90%	61%	80%	71%	74%	77%	74%	71%	74%	59%	77%	109%	140%
Inhambane	Inharrime	FY18	Scale Up Agg	22%	45%	57%	98%	119%	119%	61%	51%	49%	46%	6%	44%	17%	43%	22%	64%	24%	65%	37%	64%	37%	62%	106%	104%
Inhambane	Inharrime	FY19	Scale Up Sat	27%	55%	69%	121%	145%	144%	74%	63%	52%	50%	7%	48%	18%	47%	24%	69%	26%	70%	40%	68%	40%	67%	114%	111%
Inhambane	Inharrime	FY20	Scale Up	39%	66%	89%	121%	145%	144%	74%	65%	64%	68%	29%	66%	36%	61%	43%	74%	46%	70%	55%	69%	48%	67%	114%	111%
Inhambane	Inharrime	FY21	Scale Up	64%	82%	118%	121%	145%	144%	75%	77%	80%	95%	62%	92%	63%	82%	72%	80%	76%	71%	77%	69%	59%	69%	114%	111%
Inhambane	Inhassoro	FY18	Scale Up Sat	0%	35%	45%	55%	74%	62%	54%	75%	30%	45%	11%	51%	13%	61%	24%	84%	36%	103%	40%	89%	38%	90%	94%	107%
Inhambane	Inhassoro	FY19	Sustained	0%	38%	47%	59%	79%	67%	59%	81%	32%	48%	12%	55%	15%	66%	26%	91%	39%	113%	44%	97%	42%	98%	102%	117%
Inhambane	Inhassoro	FY20	Scale Up	17%	54%	81%	85%	84%	69%	60%	81%	49%	67%	33%	71%	33%	75%	45%	92%	55%	113%	58%	97%	49%	98%	102%	117%
Inhambane	Inhassoro	FY21	Scale Up	46%	77%	132%	119%	85%	78%	62%	88%	72%	95%	64%	93%	62%	88%	73%	94%	81%	113%	79%	97%	60%	98%	102%	117%
Zambezia	Inhassunge	FY18	Scale Up Agg	53%	53%	72%	91%	61%	67%	44%	45%	22%	37%	44%	68%	46%	70%	43%	75%	42%	60%	37%	59%	31%	41%	40%	41%

Zambezia	Inhassunge	FY19	Scale Up Agg	58%	58%	79%	99%	67%	73%	48%	49%	24%	40%	48%	75%	51%	77%	47%	83%	46%	66%	40%	64%	34%	45%	44%	45%
Zambezia	Inhassunge	FY20	Scale Up	63%	66%	85%	99%	76%	78%	58%	58%	32%	62%	64%	84%	63%	83%	60%	86%	60%	75%	54%	73%	47%	53%	54%	55%
Zambezia	Inhassunge	FY21	Scale Up	69%	77%	95%	100%	87%	86%	73%	73%	44%	93%	88%	99%	82%	93%	79%	91%	80%	88%	73%	86%	66%	65%	68%	70%
Inhambane	Jangamo	FY18	Sustained	69%	34%	45%	44%	45%	54%	35%	42%	8%	22%	4%	32%	7%	42%	18%	61%	24%	74%	24%	79%	26%	82%	76%	138%
Inhambane	Jangamo	FY19	Attained	91%	45%	58%	55%	58%	69%	44%	53%	9%	25%	5%	36%	8%	47%	20%	70%	27%	84%	27%	90%	30%	93%	86%	156%
Inhambane	Jangamo	FY20	Scale Up	92%	59%	85%	83%	68%	72%	45%	54%	31%	52%	28%	58%	29%	62%	41%	74%	47%	84%	45%	90%	39%	93%	88%	156%
Inhambane	Jangamo	FY21	Scale Up	91%	73%	126%	120%	71%	79%	47%	71%	63%	93%	62%	90%	59%	82%	71%	80%	77%	84%	72%	90%	52%	93%	90%	156%
Cidade De Maputo	Kamavota	FY18	Scale Up Sat	42%	44%	90%	97%	106%	124%	92%	100%	79%	74%	47%	127%	63%	122%	89%	134%	94%	133%	76%	100%	62%	64%	75%	79%
Cidade De Maputo	Kamavota	FY19	Scale Up Sat	44%	50%	91%	100%	108%	127%	94%	103%	81%	76%	48%	131%	65%	126%	92%	137%	96%	137%	78%	103%	64%	66%	77%	81%
Cidade De Maputo	Kamavota	FY20	Attained	66%	73%	97%	100%	108%	127%	96%	103%	85%	95%	68%	131%	85%	126%	100%	137%	100%	137%	90%	103%	71%	70%	89%	89%
Cidade De Maputo	Kamavota	FY21	Scale Up	81%	92%	101%	100%	108%	127%	98%	103%	88%	108%	83%	131%	100%	126%	106%	137%	102%	137%	100%	103%	76%	73%	98%	95%
Cidade De Maputo	Kamaxakeni	FY18	Scale Up Sat	41%	17%	49%	61%	66%	84%	59%	72%	56%	64%	38%	79%	36%	73%	53%	80%	60%	93%	56%	87%	49%	63%	65%	70%
Cidade De Maputo	Kamaxakeni	FY19	Scale Up Sat	45%	14%	50%	62%	67%	87%	61%	74%	57%	66%	39%	81%	37%	74%	54%	82%	62%	95%	58%	89%	50%	65%	66%	71%

Cidade De Maputo	Kamaxakeni	FY20	Scale Up Sat	66%	54%	84%	115%	79%	103%	74%	77%	66%	92%	63%	143%	74%	157%	98%	106%	97%	104%	82%	93%	59%	69%	84%	83%
Cidade De Maputo	Kamaxakeni	FY21	Scale Up	82%	82%	110%	153%	88%	114%	84%	79%	73%	112%	80%	189%	101%	217%	131%	124%	123%	110%	99%	96%	66%	72%	97%	92%
Cidade De Maputo	Kampfumu	FY18	Scale Up Sat	88%	132%	171%	222%	214%	280%	266%	298%	249%	250%	145%	333%	132%	455%	213%	557%	213%	535%	164%	396%	135%	315%	148%	341%
Cidade De Maputo	Kampfumu	FY19	Scale Up Sat	100%	114%	169%	222%	214%	279%	265%	298%	250%	249%	144%	333%	131%	454%	213%	556%	212%	534%	163%	395%	135%	314%	148%	341%
Cidade De Maputo	Kampfumu	FY20	Scale Up	100%	114%	169%	222%	214%	279%	265%	298%	250%	249%	144%	333%	131%	454%	213%	556%	212%	534%	163%	395%	135%	314%	148%	341%
Cidade De Maputo	Kampfumu	FY21	Attained	100%	114%	169%	222%	214%	279%	265%	298%	250%	249%	144%	333%	131%	454%	213%	556%	212%	534%	163%	395%	135%	314%	148%	341%
Cidade De Maputo	Kamubukwana	FY18	Scale Up Sat	38%	52%	66%	65%	67%	96%	53%	63%	41%	44%	27%	78%	33%	80%	51%	81%	52%	79%	37%	49%	28%	34%	34%	42%
Cidade De Maputo	Kamubukwana	FY19	Scale Up Sat	37%	52%	67%	65%	68%	97%	53%	64%	41%	44%	27%	78%	34%	81%	51%	82%	53%	79%	37%	50%	28%	34%	34%	42%
Cidade De Maputo	Kamubukwana	FY20	Scale Up	61%	74%	89%	113%	80%	101%	69%	68%	54%	87%	55%	149%	72%	143%	98%	106%	96%	117%	72%	68%	42%	42%	69%	67%
Cidade De Maputo	Kamubukwana	FY21	Scale Up	80%	90%	107%	149%	88%	104%	81%	71%	63%	119%	76%	202%	101%	188%	133%	124%	129%	145%	99%	81%	51%	47%	95%	85%
Cidade De Maputo	Kanyaka	FY18	Scale Up Sat	0%	0%	47%	0%	114%	114%	80%	89%	63%	107%	0%	80%	31%	154%	56%	162%	84%	128%	77%	110%	37%	91%	93%	66%
Cidade De Maputo	Kanyaka	FY19	Scale Up Sat	0%	0%	33%	0%	100%	100%	67%	75%	56%	83%	0%	63%	21%	124%	43%	129%	68%	100%	61%	88%	29%	71%	74%	52%
Cidade De Maputo	Kanyaka	FY20	Scale Up	39%	46%	79%	138%	100%	100%	78%	78%	65%	96%	39%	184%	67%	124%	98%	129%	97%	100%	83%	92%	42%	74%	88%	72%

Cidade De Maputo	Kanyaka	FY21	Scale Up	100%	100%	100%	233%	100%	100%	89%	75%	67%	108%	67%	275%	100%	124%	139%	129%	121%	100%	100%	96%	51%	76%	98%	87%
Cidade De Maputo	Katembe	FY18	Scale Up Sat	72%	36%	52%	82%	90%	64%	79%	89%	47%	60%	37%	136%	77%	159%	92%	141%	75%	123%	53%	75%	38%	60%	52%	102%
Cidade De Maputo	Katembe	FY19	Scale Up Sat	67%	33%	50%	87%	90%	66%	81%	91%	46%	60%	36%	135%	77%	157%	91%	140%	74%	122%	52%	75%	37%	59%	51%	101%
Cidade De Maputo	Katembe	FY20	Scale Up	80%	64%	84%	105%	94%	107%	88%	92%	57%	91%	61%	135%	91%	157%	100%	140%	98%	122%	79%	84%	49%	64%	77%	101%
Cidade De Maputo	Katembe	FY21	Scale Up	100%	100%	113%	120%	97%	138%	91%	93%	67%	113%	79%	135%	100%	157%	106%	140%	116%	122%	99%	90%	57%	67%	96%	101%
Niassa	Lago	FY18	Sustained	0%	12%	22%	39%	55%	69%	18%	49%	49%	23%	11%	27%	20%	50%	32%	55%	34%	41%	33%	25%	32%	22%	24%	31%
Niassa	Lago	FY19	Sustained	0%	13%	23%	39%	56%	69%	18%	48%	48%	22%	11%	27%	20%	50%	31%	55%	34%	41%	33%	25%	32%	22%	24%	31%
Niassa	Lago	FY20	Scale Up		49%	53%	64%	72%	81%	42%	64%	61%	41%	29%	42%	34%	59%	44%	64%	47%	54%	46%	41%	43%	36%	37%	43%
Niassa	Lago	FY21	Scale Up		87%	109%	112%	105%	105%	87%	93%	85%	73%	61%	68%	58%	76%	65%	80%	71%	78%	71%	73%	66%	64%	61%	64%
Nampula	Lalaua	FY18	Sustained	20%	60%	34%	24%	26%	17%	17%	25%	6%	19%	14%	35%	20%	49%	30%	58%	30%	46%	26%	43%	36%	20%	30%	15%
Nampula	Lalaua	FY19	Sustained	20%	60%	33%	24%	26%	17%	17%	25%	6%	19%	14%	35%	20%	49%	30%	58%	30%	46%	26%	43%	36%	20%	30%	15%
Nampula	Lalaua	FY20	Scale Up	33%	68%	51%	46%	40%	37%	33%	43%	21%	39%	30%	54%	39%	65%	43%	70%	45%	58%	37%	52%	47%	30%	47%	25%
Nampula	Lalaua	FY21	Scale Up	50%	80%	82%	85%	66%	75%	63%	75%	46%	75%	58%	87%	73%	94%	67%	92%	73%	79%	56%	68%	67%	46%	77%	42%

Nampula	Larde	FY18	Sustained	64%	116%	65%	49%	21%	29%	0%	9%	19%	39%	27%	57%	32%	49%	30%	34%	23%	33%	27%	20%	22%	17%	26%	16%
Nampula	Larde	FY19	new	50%	90%	51%	38%	16%	22%	0%	7%	14%	30%	21%	44%	25%	38%	24%	26%	18%	26%	21%	16%	17%	13%	20%	12%
Nampula	Larde	FY20	Central Support	58%	92%	64%	56%	32%	42%		30%	28%	48%	35%	60%	43%	58%	38%	47%	36%	42%	32%	29%	32%	23%	40%	22%
Nampula	Larde	FY21	Central Support	70%	95%	87%	88%	60%	76%		70%	51%	79%	61%	89%	75%	93%	64%	86%	68%	71%	53%	53%	57%	41%	74%	40%
Niassa	Lichinga	FY18	Scale Up Sat	21%	15%	29%	44%	55%	59%	42%	60%	32%	28%	15%	42%	22%	49%	35%	59%	41%	55%	36%	47%	42%	41%	52%	48%
Niassa	Lichinga	FY19	Scale Up Sat	23%	15%	30%	45%	57%	61%	44%	61%	34%	28%	15%	43%	23%	50%	36%	61%	42%	57%	37%	49%	43%	42%	53%	50%
Niassa	Lichinga	FY20	Attained	60%	50%	57%	68%	73%	76%	60%	73%	50%	46%	33%	55%	37%	60%	48%	68%	54%	67%	49%	59%	52%	53%	62%	58%
Niassa	Lichinga	FY21	Scale Up	100%	89%	109%	112%	105%	106%	91%	95%	81%	75%	63%	75%	59%	76%	67%	83%	75%	84%	73%	81%	71%	74%	76%	74%
Gaza	Limpopo	FY18	Scale Up Sat	33%	39%	100%	92%	83%	89%	61%	60%	30%	35%	15%	63%	22%	58%	39%	71%	39%	72%	35%	65%	32%	52%	83%	79%
Gaza	Limpopo	FY19	new	34%	38%	105%	97%	87%	93%	64%	63%	32%	37%	15%	66%	23%	60%	40%	75%	41%	76%	37%	68%	33%	55%	87%	83%
Gaza	Limpopo	FY20	Scale Up	56%	59%	105%	102%	90%	95%	65%	64%	45%	50%	33%	92%	43%	76%	56%	77%	54%	76%	50%	69%	41%	56%	89%	84%
Gaza	Limpopo	FY21	Scale Up	90%	90%	105%	109%	93%	102%	69%	67%	67%	71%	62%	134%	75%	100%	82%	80%	76%	77%	71%	72%	54%	58%	94%	90%
Nampula	Liupo	FY18	Sustained	29%	87%	52%	17%	42%	35%	12%	25%	24%	53%	10%	41%	25%	50%	25%	51%	47%	40%	33%	43%	30%	23%	40%	15%

Nampula	Liupo	FY19	new	17%	50%	30%	10%	24%	20%	7%	14%	14%	30%	6%	23%	15%	29%	14%	29%	27%	23%	19%	25%	17%	13%	23%	9%
Nampula	Liupo	FY20	Central Support	30%	60%	48%	36%	38%	40%	25%	35%	27%	48%	23%	45%	35%	52%	31%	50%	43%	40%	31%	37%	32%	23%	42%	19%
Nampula	Liupo	FY21	Central Support	50%	83%	80%	85%	62%	75%	57%	71%	52%	79%	53%	84%	72%	92%	60%	86%	72%	70%	52%	58%	58%	41%	75%	38%
Zambezia	Luabo	FY18	Scale Up Agg	0%	0%	48%	33%	18%	25%	32%	32%	3%	25%	40%	54%	26%	49%	23%	54%	31%	32%	28%	27%	14%	24%	31%	18%
Zambezia	Luabo	FY19	new	0%	0%	29%	20%	11%	15%	19%	19%	2%	15%	24%	33%	15%	29%	14%	32%	18%	19%	17%	16%	8%	14%	19%	11%
Zambezia	Luabo	FY20	Central Support		19%	51%	47%	33%	32%	35%	34%	12%	45%	48%	58%	37%	49%	35%	46%	39%	40%	35%	37%	26%	27%	33%	27%
Zambezia	Luabo	FY21	Central Support		50%	84%	87%	65%	57%	57%	57%	28%	90%	83%	96%	69%	77%	66%	65%	70%	70%	62%	68%	53%	46%	53%	52%
Zambezia	Lugela	FY18	Scale Up Agg	34%	46%	55%	57%	28%	34%	9%	21%	11%	30%	19%	63%	25%	55%	32%	45%	25%	37%	20%	26%	18%	23%	25%	22%
Zambezia	Lugela	FY19	Sustained	41%	56%	65%	68%	33%	42%	11%	26%	14%	40%	26%	85%	33%	73%	43%	60%	34%	50%	26%	34%	24%	31%	33%	30%
Zambezia	Lugela	FY20	Scale Up	48%	64%	76%	79%	50%	53%	29%	40%	23%	62%	49%	91%	50%	81%	57%	68%	51%	63%	43%	51%	39%	41%	45%	43%
Zambezia	Lugela	FY21	Scale Up	59%	75%	92%	94%	74%	71%	54%	61%	37%	93%	83%	99%	75%	91%	78%	79%	76%	82%	66%	75%	61%	57%	62%	62%
Gaza	Mabalane	FY18	Sustained	133%	25%	88%	63%	72%	61%	49%	47%	29%	48%	21%	71%	37%	72%	54%	64%	52%	87%	48%	78%	37%	62%	124%	119%

Gaza	Mabalane	FY19	Scale Up Agg	150%	33%	100%	73%	83%	70%	57%	54%	31%	50%	22%	75%	39%	77%	58%	68%	55%	93%	51%	83%	39%	66%	132%	127%
Gaza	Mabalane	FY20	Scale Up	150%	56%	100%	118%	88%	82%	58%	55%	44%	60%	38%	94%	55%	86%	69%	71%	65%	93%	61%	84%	46%	67%	132%	127%
Gaza	Mabalane	FY21	Scale Up	150%	83%	100%	188%	92%	107%	62%	59%	66%	77%	66%	124%	80%	100%	88%	75%	82%	93%	77%	85%	59%	69%	132%	127%
Inhambane	Mabote	FY18	Sustained	18%	32%	42%	57%	73%	75%	65%	83%	22%	43%	8%	45%	17%	54%	25%	80%	36%	97%	48%	102%	45%	76%	97%	127%
Inhambane	Mabote	FY19	Attained	18%	45%	56%	77%	99%	100%	87%	112%	24%	46%	8%	49%	19%	58%	27%	86%	39%	105%	52%	110%	49%	82%	104%	136%
Inhambane	Mabote	FY20	Scale Up	32%	59%	84%	92%	99%	100%	87%	112%	42%	66%	30%	66%	37%	69%	45%	88%	56%	105%	64%	110%	55%	82%	104%	136%
Inhambane	Mabote	FY21	Scale Up	55%	73%	127%	110%	99%	100%	87%	112%	69%	95%	63%	92%	63%	86%	73%	91%	81%	105%	82%	110%	65%	83%	104%	136%
Tete	Macanga	FY18	Sustained	0%	31%	22%	38%	31%	42%	25%	28%	35%	28%	28%	87%	75%	108%	100%	107%	83%	73%	55%	50%	45%	37%	37%	47%
Tete	Macanga	FY19	Sustained	40%	40%	29%	48%	39%	54%	32%	36%	44%	35%	35%	111%	95%	136%	126%	135%	105%	93%	69%	63%	57%	47%	47%	60%
Tete	Macanga	FY20	Scale Up		76%	61%	69%	65%	73%	44%	50%	56%	52%	48%	111%	96%	136%	126%	135%	105%	94%	75%	70%	64%	54%	55%	65%
Tete	Macanga	FY21	Scale Up		100%	119%	110%	115%	112%	65%	73%	78%	78%	71%	111%	97%	136%	126%	135%	105%	96%	87%	84%	76%	68%	69%	74%
Manica	Macate	FY18	Sustained	0%	39%	87%	92%	37%	19%	27%	19%	12%	54%	19%	80%	54%	126%	56%	89%	60%	67%	48%	58%	34%	41%	42%	42%
Manica	Macate	FY19	new	0%	38%	94%	100%	40%	20%	30%	21%	13%	58%	21%	86%	59%	136%	61%	96%	65%	73%	51%	63%	37%	44%	45%	45%

Manica	Macate	FY20	Scale Up	34%	60%	97%	100%	62%	51%	45%	38%	30%	67%	36%	90%	67%	136%	68%	96%	71%	78%	59%	69%	44%	51%	52%	51%
Manica	Macate	FY21	Scale Up	113%	113%	103%	100%	112%	122%	80%	79%	69%	88%	72%	97%	84%	136%	85%	98%	87%	89%	77%	82%	61%	68%	68%	65%
Sofala	Machanga	FY18	Sustained	0%	0%	57%	87%	49%	85%	22%	47%	19%	30%	10%	49%	20%	62%	35%	72%	51%	64%	40%	52%	29%	35%	38%	22%
Sofala	Machanga	FY19	Attained	0%	0%	55%	84%	47%	83%	21%	46%	18%	29%	10%	47%	20%	60%	34%	69%	49%	62%	39%	50%	28%	34%	36%	22%
Sofala	Machanga	FY20	Scale Up			72%	90%	67%	90%	41%	60%	39%	44%	30%	58%	35%	67%	46%	75%	59%	69%	50%	59%	38%	45%	45%	35%
Sofala	Machanga	FY21	Scale Up			107%	104%	109%	105%	85%	90%	85%	75%	73%	78%	67%	81%	71%	86%	80%	85%	73%	80%	60%	68%	64%	66%
Manica	Macharze	FY18	Scale Up Sat	8%	23%	46%	70%	45%	53%	29%	24%	13%	32%	14%	50%	40%	77%	41%	67%	46%	59%	43%	54%	34%	39%	46%	34%
Manica	Macharze	FY19	Scale Up Agg	5%	18%	36%	53%	35%	41%	22%	18%	10%	25%	11%	38%	31%	59%	31%	51%	35%	45%	33%	41%	26%	30%	35%	26%
Manica	Macharze	FY20	Scale Up	37%	47%	66%	79%	58%	64%	39%	37%	28%	42%	29%	54%	44%	67%	44%	60%	47%	55%	44%	51%	35%	40%	43%	35%
Manica	Macharze	FY21	Scale Up	109%	114%	134%	138%	113%	116%	79%	78%	69%	79%	69%	89%	74%	84%	73%	80%	76%	78%	69%	72%	55%	60%	62%	53%
Cabo Delgado	Macomia	FY18	Scale Up Agg	13%	20%	53%	50%	19%	32%	12%	22%	5%	30%	14%	37%	18%	34%	22%	47%	29%	43%	27%	38%	28%	26%	38%	34%
Cabo Delgado	Macomia	FY19	Scale Up Agg	17%	22%	65%	62%	23%	39%	14%	27%	5%	32%	15%	40%	20%	37%	24%	51%	32%	47%	29%	42%	31%	29%	41%	38%
Cabo Delgado	Macomia	FY20	Scale Up	33%	38%	94%	102%	47%	63%	29%	46%	14%	60%	27%	60%	31%	54%	39%	64%	43%	56%	40%	51%	39%	39%	48%	44%

Cabo Delgado	Macomia	FY21	Scale Up	67%	72%	148%	178%	94%	109%	58%	84%	31%	112%	49%	100%	51%	87%	69%	90%	65%	73%	61%	68%	55%	58%	60%	57%
Manica	Macossa	FY18	Sustained	19%	24%	35%	40%	20%	23%	13%	15%	11%	29%	19%	51%	29%	58%	34%	58%	35%	53%	27%	42%	24%	34%	40%	50%
Manica	Macossa	FY19	Sustained	100%	75%	25%	19%	12%	12%	23%	17%	4%	83%	50%	60%	57%	50%	47%	50%	48%	56%	44%	58%	54%	77%	49%	70%
Manica	Macossa	FY20	Central Support	100%	84%	60%	64%	44%	46%	40%	36%	23%	87%	60%	70%	66%	60%	57%	58%	57%	64%	53%	65%	60%	80%	56%	73%
Manica	Macossa	FY21	Central Support	100%	100%	138%	163%	118%	124%	80%	77%	68%	94%	83%	93%	84%	81%	80%	80%	80%	82%	74%	80%	72%	87%	71%	81%
Zambezia	Maganja Da Costa	FY18	Scale Up Agg	29%	59%	77%	72%	52%	72%	28%	31%	13%	39%	43%	67%	49%	67%	53%	74%	41%	64%	36%	47%	31%	31%	41%	29%
Zambezia	Maganja Da Costa	FY19	Scale Up Agg	33%	66%	85%	79%	58%	79%	31%	34%	15%	44%	49%	76%	55%	76%	60%	83%	46%	72%	41%	53%	35%	35%	46%	33%
Zambezia	Maganja Da Costa	FY20	Scale Up	41%	72%	90%	86%	68%	83%	44%	46%	24%	64%	65%	85%	67%	82%	70%	86%	60%	79%	54%	65%	47%	44%	56%	45%
Zambezia	Maganja Da Costa	FY21	Scale Up	54%	81%	97%	97%	84%	90%	64%	65%	37%	94%	89%	99%	83%	92%	84%	91%	80%	90%	73%	82%	66%	59%	69%	63%
Tete	Magoe	FY18	Sustained	12%	28%	47%	62%	51%	66%	35%	27%	22%	63%	31%	109%	62%	93%	73%	104%	68%	79%	51%	54%	38%	33%	38%	37%
Tete	Magoe	FY19	Sustained	13%	25%	48%	66%	54%	69%	36%	28%	23%	65%	33%	113%	64%	96%	76%	108%	71%	82%	53%	56%	39%	35%	39%	38%
Tete	Magoe	FY20	Scale Up	56%	70%	72%	80%	73%	82%	48%	44%	40%	75%	46%	113%	72%	96%	79%	108%	78%	86%	62%	65%	49%	44%	48%	47%
Tete	Magoe	FY21	Scale Up	75%	88%	115%	106%	111%	107%	68%	71%	70%	88%	68%	113%	84%	97%	86%	108%	92%	91%	80%	82%	67%	61%	65%	61%

Maputo	Magude	FY18	Scale Up Agg	0%	15%	26%	41%	42%	56%	48%	40%	31%	38%	7%	42%	18%	48%	30%	57%	43%	73%	42%	60%	35%	45%	56%	56%
Maputo	Magude	FY19	Scale Up Sat	0%	15%	28%	43%	45%	60%	51%	42%	33%	40%	8%	45%	19%	51%	31%	61%	46%	78%	45%	64%	37%	48%	59%	60%
Maputo	Magude	FY20	Scale Up	7%	21%	34%	48%	48%	63%	56%	49%	51%	55%	18%	55%	27%	59%	43%	65%	55%	80%	56%	68%	46%	52%	63%	61%
Maputo	Magude	FY21	Scale Up	25%	35%	46%	60%	56%	70%	67%	65%	92%	89%	43%	78%	47%	77%	72%	75%	76%	85%	82%	77%	66%	62%	73%	65%
Niassa	Majune	FY18	Sustained	7%	8%	13%	14%	13%	15%	9%	11%	6%	10%	6%	15%	8%	17%	13%	20%	14%	17%	13%	15%	11%	12%	15%	17%
Niassa	Majune	FY19	Sustained	171%	157%	0%	0%	0%	0%	23%	33%	6%	16%	8%	20%	19%	24%	20%	27%	23%	29%	0%	0%	0%	0%	23%	20%
Niassa	Majune	FY20	Central Support	171%	157%	39%	41%	38%	39%	46%	54%	30%	36%	27%	37%	33%	38%	34%	41%	38%	45%	19%	21%	17%	18%	36%	34%
Niassa	Majune	FY21	Central Support	171%	157%	111%	121%	113%	116%	87%	93%	74%	70%	60%	65%	57%	63%	59%	68%	66%	73%	57%	63%	50%	54%	59%	58%
Nampula	Malema	FY18	Scale Up Agg	22%	22%	31%	41%	29%	36%	21%	45%	8%	31%	16%	46%	22%	58%	25%	63%	30%	50%	25%	39%	32%	32%	43%	20%
Nampula	Malema	FY19	Scale Up Sat	21%	21%	29%	38%	27%	33%	19%	42%	8%	29%	15%	43%	20%	54%	23%	59%	28%	47%	24%	36%	30%	30%	40%	19%
Nampula	Malema	FY20	Scale Up	33%	37%	48%	56%	41%	50%	35%	56%	22%	47%	31%	59%	39%	69%	38%	71%	44%	59%	35%	47%	42%	38%	55%	28%
Nampula	Malema	FY21	Scale Up	54%	67%	81%	88%	65%	79%	63%	81%	47%	78%	58%	88%	73%	95%	64%	92%	72%	79%	55%	65%	64%	52%	80%	45%
Niassa	Mandimba	FY18	Scale Up Agg	19%	7%	24%	39%	32%	26%	22%	30%	9%	29%	14%	38%	14%	47%	27%	40%	23%	33%	27%	27%	23%	20%	26%	21%

Niassa	Mandimba	FY19	Sustained	19%	8%	25%	41%	33%	27%	23%	31%	10%	30%	14%	39%	14%	48%	28%	41%	24%	34%	28%	28%	23%	21%	27%	22%
Niassa	Mandimba	FY20	Scale Up	58%	45%	54%	65%	58%	55%	46%	52%	33%	47%	32%	52%	30%	58%	41%	53%	40%	49%	42%	43%	36%	35%	40%	35%
Niassa	Mandimba	FY21	Scale Up	100%	88%	110%	113%	108%	110%	88%	91%	74%	76%	63%	74%	55%	75%	63%	74%	67%	75%	69%	74%	61%	64%	62%	59%
Gaza	Mandlakaze	FY18	Scale Up Sat	42%	75%	85%	115%	118%	156%	84%	106%	51%	55%	19%	71%	32%	64%	53%	71%	60%	68%	64%	68%	51%	56%	148%	91%
Gaza	Mandlakaze	FY19	Scale Up Sat	44%	73%	88%	120%	123%	161%	87%	109%	52%	58%	20%	73%	34%	66%	55%	74%	63%	71%	67%	71%	53%	58%	153%	94%
Gaza	Mandlakaze	FY20	Scale Up	62%	83%	104%	120%	123%	161%	88%	109%	61%	66%	37%	94%	50%	80%	67%	76%	71%	71%	73%	71%	59%	59%	153%	95%
Gaza	Mandlakaze	FY21	Scale Up	94%	93%	128%	120%	123%	161%	89%	109%	77%	80%	65%	126%	78%	100%	87%	79%	85%	72%	85%	74%	68%	62%	153%	97%
Maputo	Manhiça	FY18	Scale Up Sat	16%	24%	35%	40%	59%	70%	59%	67%	37%	39%	14%	56%	24%	63%	41%	90%	57%	102%	59%	85%	49%	60%	71%	70%
Maputo	Manhiça	FY19	Scale Up Agg	18%	25%	37%	42%	62%	73%	62%	70%	39%	41%	15%	59%	26%	66%	43%	95%	60%	107%	62%	90%	51%	63%	75%	74%
Maputo	Manhiça	FY20	Scale Up	24%	30%	42%	47%	65%	75%	66%	74%	55%	55%	24%	67%	33%	71%	53%	95%	67%	107%	70%	91%	58%	66%	77%	75%
Maputo	Manhiça	FY21	Scale Up	36%	42%	53%	59%	70%	80%	75%	82%	93%	89%	47%	84%	51%	84%	77%	97%	82%	107%	88%	94%	73%	73%	83%	77%
Manica	Manica	FY18	Scale Up Agg	0%	12%	55%	55%	46%	52%	27%	31%	18%	42%	18%	71%	35%	84%	45%	76%	39%	57%	37%	47%	34%	37%	49%	52%
Manica	Manica	FY19	Scale Up Sat	0%	12%	55%	55%	46%	52%	28%	31%	18%	42%	18%	71%	35%	84%	45%	76%	39%	57%	37%	47%	34%	37%	49%	52%

Manica	Manica	FY20	Scale Up	34%	43%	76%	80%	65%	71%	44%	47%	34%	55%	34%	79%	48%	87%	55%	80%	50%	65%	47%	55%	42%	46%	55%	58%
Manica	Manica	FY21	Scale Up	111%	118%	124%	136%	110%	113%	80%	82%	72%	83%	71%	95%	75%	94%	78%	90%	77%	83%	71%	74%	60%	64%	70%	70%
Gaza	Mapai	FY18	Sustained	29%	92%	122%	60%	55%	75%	40%	41%	26%	32%	7%	69%	22%	86%	26%	73%	30%	82%	32%	70%	33%	77%	79%	91%
Gaza	Mapai	FY19	new	40%	100%	127%	64%	57%	79%	40%	42%	29%	36%	8%	78%	24%	97%	29%	83%	34%	93%	37%	79%	37%	87%	90%	103%
Gaza	Mapai	FY20	Scale Up	60%	100%	127%	124%	68%	87%	43%	44%	42%	49%	27%	95%	43%	98%	48%	85%	49%	93%	49%	80%	44%	87%	91%	103%
Gaza	Mapai	FY21	Scale Up	100%	100%	127%	216%	78%	104%	47%	49%	65%	70%	59%	122%	75%	100%	79%	87%	73%	94%	71%	81%	57%	88%	95%	103%
Tete	Marara	FY18	Sustained	0%	0%	85%	98%	45%	93%	25%	25%	21%	50%	36%	115%	103%	115%	100%	187%	115%	109%	86%	65%	53%	57%	46%	47%
Tete	Marara	FY19	new	0%	0%	89%	106%	47%	97%	26%	26%	22%	54%	38%	122%	109%	122%	106%	198%	122%	115%	91%	69%	56%	61%	49%	50%
Tete	Marara	FY20	Scale Up			94%	106%	70%	98%	40%	42%	39%	66%	51%	122%	109%	122%	106%	198%	122%	115%	93%	75%	62%	66%	57%	57%
Tete	Marara	FY21	Scale Up			106%	106%	112%	100%	62%	70%	69%	85%	71%	122%	109%	122%	106%	198%	122%	115%	96%	87%	75%	77%	71%	68%
Tete	Maravia	FY18	Sustained	0%	52%	35%	82%	37%	31%	32%	14%	6%	49%	20%	94%	40%	134%	60%	96%	66%	73%	78%	49%	45%	40%	36%	49%
Tete	Maravia	FY19	Sustained	0%	60%	41%	91%	40%	36%	35%	16%	7%	56%	24%	107%	46%	151%	68%	109%	75%	83%	88%	56%	51%	45%	41%	55%
Tete	Maravia	FY20	Central Support		84%	68%	95%	66%	63%	47%	35%	28%	67%	39%	107%	58%	151%	73%	109%	81%	86%	90%	64%	59%	53%	50%	61%

Tete	Maravia	FY21	Central Support		100%	118%	100%	114%	117%	67%	66%	62%	84%	65%	107%	74%	151%	82%	109%	93%	92%	95%	81%	73%	67%	66%	71%
Sofala	Maringue	FY18	Sustained	8%	9%	17%	19%	12%	14%	8%	9%	7%	14%	10%	24%	17%	31%	25%	35%	28%	33%	22%	27%	18%	21%	25%	28%
Sofala	Maringue	FY19	Sustained	40%	27%	0%	0%	0%	0%	10%	2%	13%	39%	18%	49%	44%	51%	44%	57%	50%	67%	0%	0%	0%	0%	43%	29%
Sofala	Maringue	FY20	Central Support	57%	49%	37%	39%	37%	41%	33%	27%	35%	52%	37%	59%	55%	60%	54%	65%	59%	74%	17%	18%	14%	16%	50%	41%
Sofala	Maringue	FY21	Central Support	90%	91%	114%	122%	116%	128%	84%	82%	83%	78%	75%	79%	78%	77%	76%	80%	80%	87%	56%	59%	44%	51%	67%	69%
Maputo	Marracuene	FY18	Scale Up Agg	15%	15%	24%	26%	31%	36%	37%	38%	30%	24%	9%	32%	14%	34%	25%	44%	27%	42%	23%	35%	21%	26%	38%	44%
Maputo	Marracuene	FY19	Scale Up Agg	18%	18%	26%	28%	35%	39%	41%	42%	34%	26%	10%	35%	15%	38%	28%	49%	29%	47%	26%	39%	23%	29%	42%	49%
Maputo	Marracuene	FY20	Scale Up Sat	23%	24%	32%	35%	38%	44%	47%	49%	51%	44%	20%	47%	24%	48%	40%	54%	41%	51%	41%	45%	33%	35%	48%	51%
Maputo	Marracuene	FY21	Scale Up	37%	38%	45%	50%	47%	54%	61%	65%	92%	86%	44%	74%	44%	72%	70%	68%	69%	63%	76%	61%	58%	48%	61%	55%
Sofala	Marromeu	FY18	Scale Up Agg	44%	33%	40%	61%	16%	19%	12%	14%	11%	26%	18%	51%	26%	47%	30%	44%	31%	30%	23%	22%	22%	17%	24%	17%
Sofala	Marromeu	FY19	Scale Up Sat	46%	36%	43%	65%	18%	21%	13%	15%	12%	28%	19%	54%	28%	50%	33%	47%	33%	32%	25%	23%	24%	19%	25%	18%
Sofala	Marromeu	FY20	Scale Up	61%	55%	64%	79%	48%	53%	35%	37%	34%	44%	37%	63%	42%	58%	45%	56%	46%	45%	38%	37%	34%	31%	35%	32%

Sofala	Marromeu	FY21	Scale Up	89%	89%	109%	107%	114%	123%	84%	85%	83%	74%	76%	81%	70%	76%	71%	75%	74%	73%	67%	68%	58%	60%	57%	64%
Niassa	Marrupa	FY18	Sustained	44%	17%	33%	37%	33%	42%	8%	16%	4%	27%	3%	53%	14%	32%	22%	42%	21%	31%	12%	22%	19%	10%	17%	10%
Niassa	Marrupa	FY19	Sustained	38%	14%	31%	34%	31%	42%	7%	17%	4%	27%	3%	52%	13%	31%	22%	41%	21%	30%	12%	22%	19%	10%	16%	10%
Niassa	Marrupa	FY20	Central Support	67%	49%	58%	62%	57%	64%	34%	43%	28%	44%	23%	62%	29%	44%	35%	53%	37%	46%	29%	38%	32%	26%	31%	26%
Niassa	Marrupa	FY21	Central Support	100%	86%	107%	114%	109%	110%	83%	90%	74%	75%	58%	79%	54%	67%	60%	74%	65%	74%	63%	71%	59%	59%	56%	53%
Gaza	Massangena	FY18	Sustained	41%	41%	73%	39%	74%	61%	55%	62%	14%	32%	8%	57%	9%	55%	31%	52%	26%	74%	24%	75%	34%	59%	99%	85%
Gaza	Massangena	FY19	Sustained	67%	67%	100%	54%	104%	83%	77%	86%	15%	37%	9%	65%	10%	63%	36%	59%	30%	85%	28%	86%	39%	67%	113%	97%
Gaza	Massangena	FY20	Central Support	78%	78%	100%	130%	104%	89%	78%	86%	31%	49%	28%	92%	33%	78%	53%	63%	45%	85%	42%	87%	46%	68%	113%	97%
Gaza	Massangena	FY21	Central Support	100%	100%	100%	246%	104%	104%	80%	86%	59%	69%	60%	134%	71%	99%	81%	67%	72%	86%	67%	88%	59%	70%	113%	98%
Inhambane	Massinga	FY18	Scale Up Agg	22%	51%	58%	67%	76%	78%	55%	84%	35%	41%	10%	39%	9%	43%	21%	61%	20%	70%	24%	68%	30%	65%	77%	104%
Inhambane	Massinga	FY19	Scale Up Sat	28%	69%	77%	87%	98%	101%	72%	109%	38%	45%	11%	43%	10%	47%	23%	67%	22%	77%	27%	75%	33%	72%	85%	115%
Inhambane	Massinga	FY20	Scale Up	40%	77%	92%	95%	99%	101%	72%	109%	53%	65%	32%	62%	30%	62%	42%	72%	43%	78%	45%	76%	42%	72%	87%	115%

Inhambane	Massinga	FY21	Scale Up	62%	86%	114%	106%	99%	101%	73%	109%	75%	95%	64%	91%	60%	82%	72%	79%	75%	78%	72%	76%	54%	73%	90%	115%
Gaza	Massingir	FY18	Sustained	65%	109%	88%	113%	51%	68%	43%	47%	20%	59%	13%	71%	20%	72%	28%	71%	29%	76%	35%	69%	34%	55%	107%	106%
Gaza	Massingir	FY19	Sustained	67%	117%	100%	128%	59%	78%	48%	54%	21%	60%	14%	73%	21%	74%	29%	72%	30%	77%	35%	71%	35%	56%	109%	108%
Gaza	Massingir	FY20	Scale Up	78%	117%	100%	128%	70%	86%	50%	55%	36%	68%	32%	94%	41%	84%	47%	74%	45%	78%	48%	71%	42%	57%	109%	108%
Gaza	Massingir	FY21	Scale Up	100%	117%	100%	128%	78%	105%	55%	59%	62%	82%	61%	127%	74%	100%	79%	78%	71%	79%	71%	74%	55%	60%	109%	108%
Maputo	Matola	FY18	Scale Up Agg	7%	16%	21%	25%	25%	29%	29%	32%	26%	22%	9%	28%	11%	32%	17%	44%	24%	48%	25%	42%	21%	35%	36%	50%
Maputo	Matola	FY19	Scale Up Agg	8%	17%	22%	26%	27%	31%	31%	35%	28%	24%	10%	30%	12%	34%	18%	47%	25%	52%	27%	45%	23%	37%	39%	54%
Maputo	Matola	FY20	Scale Up	14%	23%	28%	33%	31%	36%	38%	42%	47%	42%	20%	43%	21%	45%	32%	53%	38%	56%	41%	51%	33%	42%	45%	56%
Maputo	Matola	FY21	Scale Up	29%	37%	42%	48%	41%	47%	54%	60%	92%	86%	44%	72%	42%	70%	66%	66%	67%	67%	76%	65%	58%	54%	59%	60%
Maputo	Matutuine	FY18	Scale Up Agg	18%	6%	23%	28%	36%	36%	55%	53%	33%	36%	14%	35%	13%	39%	26%	46%	31%	51%	33%	47%	33%	36%	42%	40%
Maputo	Matutuine	FY19	Scale Up Sat	20%	7%	25%	30%	39%	38%	59%	57%	35%	39%	15%	38%	14%	42%	28%	49%	33%	55%	35%	50%	35%	38%	45%	43%
Maputo	Matutuine	FY20	Scale Up	25%	14%	31%	36%	42%	42%	63%	62%	52%	54%	24%	49%	23%	51%	41%	55%	44%	59%	48%	56%	44%	43%	50%	45%
Maputo	Matutuine	FY21	Scale Up	40%	29%	45%	51%	51%	53%	72%	74%	93%	89%	47%	75%	44%	73%	71%	68%	70%	69%	79%	69%	65%	55%	63%	50%

Niassa	Maua	FY18	Sustained	0%	15%	31%	19%	16%	25%	21%	39%	11%	39%	16%	59%	13%	51%	27%	46%	22%	23%	20%	18%	12%	13%	23%	12%
Niassa	Maua	FY19	Sustained	0%	11%	31%	20%	16%	26%	21%	39%	11%	38%	16%	58%	12%	50%	27%	45%	21%	23%	20%	17%	11%	13%	23%	12%
Niassa	Maua	FY20	Central Support	48%	47%	58%	53%	48%	54%	44%	58%	33%	53%	33%	66%	28%	59%	40%	56%	37%	40%	35%	35%	26%	29%	36%	27%
Niassa	Maua	FY21	Central Support	100%	89%	109%	117%	109%	112%	87%	92%	76%	79%	64%	81%	54%	76%	62%	75%	65%	71%	66%	70%	55%	60%	59%	54%
Niassa	Mavago	FY18	Sustained	14%	17%	22%	25%	20%	23%	13%	16%	10%	18%	11%	27%	16%	36%	23%	41%	26%	40%	24%	38%	22%	32%	35%	55%
Niassa	Mavago	FY19	Sustained	50%	50%	0%	0%	0%	0%	17%	0%	18%	45%	25%	47%	47%	51%	48%	58%	54%	69%	0%	0%	0%	0%	72%	52%
Niassa	Mavago	FY20	Central Support	74%	70%	39%	41%	38%	39%	41%	31%	39%	58%	40%	58%	56%	60%	57%	66%	63%	76%	19%	21%	17%	18%	77%	60%
Niassa	Mavago	FY21	Central Support	100%	100%	111%	122%	108%	117%	83%	92%	73%	81%	68%	76%	71%	77%	73%	81%	79%	88%	58%	63%	50%	53%	84%	76%
Inhambane	Maxixe	FY18	Scale Up Sat	68%	28%	55%	54%	84%	114%	94%	118%	61%	47%	9%	33%	9%	30%	16%	48%	22%	54%	29%	59%	34%	63%	107%	106%
Inhambane	Maxixe	FY19	Scale Up Sat	71%	30%	58%	57%	88%	120%	99%	124%	61%	48%	9%	33%	10%	30%	16%	49%	22%	56%	30%	60%	35%	64%	110%	108%
Inhambane	Maxixe	FY20	Scale Up	76%	47%	85%	84%	90%	120%	99%	124%	71%	67%	31%	56%	30%	49%	37%	56%	43%	56%	47%	61%	43%	65%	110%	108%
Inhambane	Maxixe	FY21	Scale Up	86%	70%	125%	120%	92%	120%	99%	124%	84%	95%	63%	90%	59%	76%	69%	67%	75%	57%	73%	61%	55%	66%	110%	108%

Niassa	Mecanhelas	FY18	Scale Up Agg	18%	0%	27%	37%	27%	39%	13%	18%	13%	28%	14%	51%	22%	47%	34%	57%	31%	35%	23%	28%	19%	18%	20%	17%
Niassa	Mecanhelas	FY19	Sustained	17%	0%	25%	33%	24%	35%	12%	17%	12%	25%	13%	47%	20%	43%	31%	52%	28%	32%	21%	25%	17%	17%	19%	15%
Niassa	Mecanhelas	FY20	Scale Up	57%	41%	54%	61%	53%	60%	38%	42%	34%	43%	31%	58%	35%	53%	43%	61%	43%	47%	36%	41%	31%	32%	33%	30%
Niassa	Mecanhelas	FY21	Scale Up	100%	85%	110%	115%	109%	109%	85%	90%	75%	74%	62%	77%	58%	72%	64%	79%	68%	74%	66%	73%	58%	62%	58%	56%
Nampula	Meconta	FY18	Sustained	80%	60%	85%	94%	69%	107%	48%	67%	17%	42%	17%	60%	22%	62%	26%	66%	32%	51%	32%	46%	36%	37%	43%	34%
Nampula	Meconta	FY19	Sustained	70%	53%	75%	83%	62%	95%	43%	59%	15%	37%	15%	53%	19%	55%	23%	58%	28%	45%	29%	41%	32%	33%	38%	30%
Nampula	Meconta	FY20	Scale Up	75%	63%	82%	88%	69%	96%	54%	69%	28%	53%	30%	67%	39%	69%	38%	70%	44%	57%	39%	50%	44%	41%	53%	38%
Nampula	Meconta	FY21	Scale Up	83%	80%	93%	97%	81%	98%	73%	87%	51%	80%	58%	90%	73%	95%	64%	92%	72%	79%	58%	67%	65%	55%	80%	52%
Nampula	Mecuburi	FY18	Sustained	37%	72%	29%	41%	11%	32%	23%	26%	8%	28%	14%	53%	20%	58%	29%	51%	29%	34%	23%	26%	23%	24%	28%	19%
Nampula	Mecuburi	FY19	Scale Up Agg	32%	62%	25%	35%	9%	28%	20%	22%	7%	24%	12%	45%	17%	50%	25%	44%	25%	29%	20%	23%	20%	21%	24%	16%
Nampula	Mecuburi	FY20	Scale Up	43%	70%	45%	54%	26%	46%	35%	41%	21%	43%	28%	61%	37%	66%	40%	60%	41%	45%	31%	35%	34%	30%	43%	26%
Nampula	Mecuburi	FY21	Scale Up	64%	86%	79%	87%	57%	78%	63%	74%	47%	77%	56%	89%	72%	95%	65%	89%	70%	72%	52%	57%	59%	46%	75%	43%
Cabo Delgado	Mecufi	FY18	Sustained	32%	65%	38%	60%	58%	27%	16%	34%	8%	16%	11%	35%	14%	37%	31%	46%	32%	41%	29%	37%	41%	33%	65%	31%

Cabo Delgado	Mecufi	FY19	Sustained	38%	75%	43%	69%	67%	31%	19%	39%	9%	18%	13%	41%	16%	43%	36%	53%	36%	47%	33%	43%	48%	39%	75%	35%
Cabo Delgado	Mecufi	FY20	Scale Up	50%	80%	90%	101%	77%	58%	33%	55%	17%	51%	25%	61%	27%	58%	49%	66%	47%	56%	44%	52%	54%	47%	78%	42%
Cabo Delgado	Mecufi	FY21	Scale Up	75%	88%	180%	162%	97%	109%	59%	87%	33%	115%	48%	100%	49%	88%	74%	90%	67%	74%	64%	69%	66%	64%	83%	56%
Niassa	Mecula	FY18	Sustained	14%	17%	25%	29%	26%	30%	16%	21%	11%	19%	12%	27%	15%	31%	19%	35%	22%	32%	20%	28%	17%	23%	24%	33%
Niassa	Mecula	FY19	Sustained	50%	50%	0%	0%	0%	0%	20%	0%	20%	52%	23%	52%	43%	49%	38%	55%	43%	63%	0%	0%	0%	0%	46%	33%
Niassa	Mecula	FY20	Central Support	74%	70%	39%	41%	38%	39%	44%	31%	40%	63%	39%	62%	54%	58%	49%	64%	54%	71%	19%	21%	17%	18%	55%	45%
Niassa	Mecula	FY21	Central Support	100%	100%	113%	125%	111%	111%	90%	89%	80%	83%	65%	80%	70%	76%	67%	79%	74%	86%	57%	64%	50%	55%	72%	65%
Cabo Delgado	Meluco	FY18	Sustained	15%	31%	26%	37%	34%	55%	12%	13%	3%	30%	6%	22%	11%	26%	15%	41%	21%	44%	23%	34%	20%	23%	43%	24%
Cabo Delgado	Meluco	FY19	Sustained	14%	29%	29%	39%	36%	56%	12%	12%	3%	31%	6%	22%	11%	27%	15%	42%	21%	45%	23%	34%	20%	23%	44%	24%
Cabo Delgado	Meluco	FY20	Scale Up	31%	43%	87%	102%	56%	73%	27%	35%	11%	59%	19%	49%	23%	47%	32%	58%	34%	54%	35%	45%	29%	34%	50%	32%
Cabo Delgado	Meluco	FY21	Scale Up	71%	71%	200%	222%	96%	107%	58%	80%	28%	113%	43%	100%	46%	85%	65%	88%	59%	72%	58%	64%	47%	55%	63%	48%
Nampula	Memba	FY18	Sustained	0%	8%	24%	28%	15%	20%	25%	25%	10%	26%	19%	52%	39%	64%	37%	60%	39%	42%	28%	27%	38%	20%	30%	16%
Nampula	Memba	FY19	Sustained	0%	7%	22%	26%	14%	18%	24%	23%	9%	24%	18%	48%	36%	59%	34%	56%	36%	39%	26%	25%	35%	18%	28%	15%

Nampula	Memba	FY20	Central Support	16%	26%	43%	48%	30%	39%	38%	41%	23%	43%	32%	63%	51%	72%	46%	68%	50%	52%	37%	37%	46%	28%	45%	25%
Nampula	Memba	FY21	Central Support	43%	59%	79%	86%	59%	75%	65%	75%	48%	76%	59%	89%	78%	96%	69%	91%	75%	76%	56%	58%	67%	45%	76%	42%
Niassa	Metarica	FY18	Sustained	0%	37%	26%	17%	21%	21%	31%	31%	16%	27%	0%	37%	15%	53%	38%	73%	25%	49%	37%	50%	24%	19%	54%	33%
Niassa	Metarica	FY19	Sustained	0%	25%	24%	12%	19%	19%	26%	26%	11%	22%	0%	30%	12%	42%	30%	58%	21%	39%	29%	40%	20%	16%	43%	27%
Niassa	Metarica	FY20	Scale Up	48%	55%	53%	48%	50%	50%	48%	49%	34%	40%	20%	44%	28%	53%	43%	66%	37%	52%	43%	53%	33%	31%	53%	40%
Niassa	Metarica	FY21	Scale Up	100%	100%	112%	118%	110%	114%	89%	89%	72%	73%	56%	69%	54%	72%	65%	82%	65%	77%	69%	78%	60%	62%	70%	62%
Cabo Delgado	Metuge	FY18	Scale Up Agg	7%	42%	59%	64%	26%	28%	3%	32%	2%	27%	9%	35%	16%	32%	21%	35%	21%	28%	21%	30%	24%	24%	37%	33%
Cabo Delgado	Metuge	FY19	Sustained	8%	46%	68%	76%	30%	32%	4%	37%	3%	31%	10%	40%	18%	37%	24%	41%	25%	32%	25%	35%	28%	28%	43%	38%
Cabo Delgado	Metuge	FY20	Scale Up	26%	57%	94%	101%	52%	58%	20%	53%	11%	59%	22%	61%	29%	54%	39%	57%	37%	44%	36%	45%	36%	38%	49%	45%
Cabo Delgado	Metuge	FY21	Scale Up	62%	77%	145%	148%	95%	109%	52%	87%	29%	113%	46%	100%	50%	87%	69%	88%	61%	66%	59%	64%	53%	58%	62%	57%
Zambezia	Milange	FY18	Scale Up Agg	5%	21%	29%	33%	24%	31%	20%	28%	11%	25%	22%	43%	24%	44%	28%	45%	27%	40%	26%	37%	26%	33%	37%	38%
Zambezia	Milange	FY19	Scale Up Sat	7%	26%	36%	39%	28%	37%	23%	33%	13%	29%	27%	52%	29%	52%	34%	54%	32%	48%	32%	45%	32%	39%	45%	46%
Zambezia	Milange	FY20	Scale Up	18%	40%	55%	60%	46%	50%	38%	46%	23%	55%	50%	70%	47%	65%	50%	63%	50%	61%	47%	59%	45%	48%	54%	56%

Zambezia	Milange	FY21	Scale Up	35%	60%	85%	89%	72%	68%	60%	65%	36%	92%	84%	97%	74%	85%	74%	76%	75%	81%	69%	79%	65%	62%	68%	71%
Maputo	Moamba	FY18	Scale Up Agg	23%	16%	29%	30%	39%	49%	39%	49%	28%	37%	12%	42%	14%	38%	24%	46%	32%	50%	32%	44%	30%	34%	42%	38%
Maputo	Moamba	FY19	Scale Up Sat	24%	17%	31%	32%	42%	53%	42%	53%	31%	39%	13%	45%	15%	41%	26%	50%	35%	54%	34%	47%	33%	37%	45%	41%
Maputo	Moamba	FY20	Scale Up	29%	23%	36%	38%	45%	57%	48%	59%	49%	54%	23%	55%	24%	50%	39%	55%	46%	58%	48%	53%	42%	42%	51%	43%
Maputo	Moamba	FY21	Scale Up	41%	38%	48%	52%	53%	64%	62%	72%	92%	89%	46%	78%	44%	73%	70%	68%	71%	68%	79%	66%	63%	54%	64%	49%
Tete	Moatize	FY18	Scale Up Sat	17%	9%	65%	66%	54%	64%	35%	33%	35%	59%	34%	130%	79%	160%	122%	134%	105%	115%	81%	71%	59%	48%	54%	48%
Tete	Moatize	FY19	Scale Up Sat	17%	13%	70%	71%	58%	69%	38%	35%	38%	63%	37%	140%	85%	171%	130%	144%	112%	123%	87%	76%	64%	52%	58%	51%
Tete	Moatize	FY20	Scale Up	58%	65%	83%	83%	76%	82%	49%	49%	52%	73%	49%	140%	88%	171%	130%	144%	112%	123%	89%	80%	69%	59%	64%	58%
Tete	Moatize	FY21	Scale Up	79%	87%	109%	105%	110%	108%	68%	73%	75%	87%	70%	140%	93%	171%	130%	144%	112%	123%	94%	90%	80%	71%	76%	69%
Cabo Delgado	Mocimboa Da Praia	FY18	Scale Up Agg	21%	21%	36%	53%	39%	48%	20%	15%	6%	22%	6%	30%	15%	34%	21%	42%	23%	35%	28%	34%	26%	31%	45%	44%
Cabo Delgado	Mocimboa Da Praia	FY19	Scale Up Agg	22%	22%	38%	55%	40%	49%	21%	15%	7%	22%	6%	31%	15%	35%	22%	43%	24%	37%	29%	35%	28%	32%	47%	46%
Cabo Delgado	Mocimboa Da Praia	FY20	Scale Up	37%	38%	89%	102%	59%	69%	34%	38%	15%	54%	19%	55%	27%	53%	38%	59%	36%	48%	40%	45%	36%	42%	52%	51%
Cabo Delgado	Mocimboa Da Praia	FY21	Scale Up	70%	70%	187%	191%	95%	107%	61%	81%	32%	114%	44%	100%	49%	87%	68%	88%	61%	68%	61%	64%	53%	60%	64%	63%

Zambezia	Mocuba	FY18	Scale Up Agg	44%	58%	67%	74%	51%	67%	34%	50%	19%	58%	36%	98%	50%	83%	53%	73%	45%	58%	40%	52%	38%	39%	58%	52%
Zambezia	Mocuba	FY19	Scale Up Sat	46%	59%	71%	78%	53%	71%	36%	53%	20%	61%	38%	103%	53%	87%	56%	77%	48%	61%	42%	55%	40%	41%	61%	54%
Zambezia	Mocuba	FY20	Scale Up	53%	67%	80%	85%	65%	77%	49%	62%	28%	75%	57%	103%	65%	91%	67%	82%	61%	71%	55%	66%	52%	50%	68%	63%
Zambezia	Mocuba	FY21	Scale Up	63%	77%	93%	96%	82%	85%	67%	75%	41%	96%	86%	103%	83%	96%	83%	88%	81%	86%	74%	83%	69%	63%	78%	75%
Zambezia	Mocubela	FY18	Scale Up Agg	38%	33%	69%	74%	34%	52%	11%	17%	21%	75%	66%	101%	53%	67%	45%	63%	42%	48%	32%	43%	29%	25%	44%	42%
Zambezia	Mocubela	FY19	new	43%	38%	78%	84%	39%	59%	13%	19%	24%	85%	75%	115%	60%	76%	51%	72%	47%	55%	36%	49%	32%	29%	50%	48%
Zambezia	Mocubela	FY20	Scale Up	50%	50%	85%	89%	54%	67%	29%	35%	32%	91%	83%	115%	70%	83%	63%	77%	61%	66%	51%	62%	46%	39%	58%	58%
Zambezia	Mocubela	FY21	Scale Up	60%	67%	95%	97%	77%	79%	54%	57%	44%	98%	94%	115%	85%	92%	81%	86%	81%	83%	71%	81%	65%	55%	71%	72%
Nampula	Mogincual	FY18	Sustained	10%	0%	19%	19%	23%	25%	0%	5%	2%	26%	4%	15%	13%	19%	11%	14%	11%	11%	6%	9%	11%	10%	17%	7%
Nampula	Mogincual	FY19	Sustained	14%	0%	27%	27%	33%	36%	0%	7%	3%	38%	6%	22%	19%	28%	16%	21%	16%	15%	9%	14%	16%	14%	25%	10%
Nampula	Mogincual	FY20	Central Support	28%		46%	48%	46%	52%		29%	18%	54%	23%	44%	39%	51%	32%	44%	34%	34%	22%	28%	31%	24%	43%	20%
Nampula	Mogincual	FY21	Central Support	57%		82%	86%	67%	82%		67%	43%	81%	54%	84%	73%	92%	61%	85%	67%	67%	46%	52%	57%	41%	75%	39%
Nampula	Mogovolas	FY18	Sustained	28%	37%	30%	49%	20%	30%	23%	27%	6%	34%	13%	41%	17%	47%	25%	40%	20%	31%	20%	20%	18%	17%	21%	14%

Nampula	Mogovolas	FY19	Sustained	29%	38%	30%	50%	21%	31%	23%	27%	6%	34%	13%	42%	17%	48%	26%	41%	21%	31%	21%	21%	19%	17%	22%	14%
Nampula	Mogovolas	FY20	Scale Up	40%	51%	49%	65%	36%	48%	38%	45%	21%	51%	29%	59%	37%	64%	40%	58%	38%	47%	32%	33%	33%	27%	41%	24%
Nampula	Mogovolas	FY21	Scale Up	61%	73%	81%	90%	62%	79%	65%	76%	46%	80%	57%	88%	72%	94%	65%	89%	69%	73%	53%	56%	58%	44%	74%	41%
Zambezia	Molumbo	FY18	Scale Up Agg	0%	14%	20%	20%	14%	16%	4%	12%	13%	19%	24%	35%	16%	31%	21%	29%	19%	28%	17%	24%	13%	17%	19%	20%
Zambezia	Molumbo	FY19	new	0%	18%	27%	28%	20%	22%	5%	17%	16%	23%	29%	43%	20%	37%	26%	35%	23%	34%	20%	29%	16%	21%	24%	24%
Zambezia	Molumbo	FY20	Scale Up	12%	34%	50%	52%	40%	38%	23%	32%	25%	51%	51%	65%	40%	55%	44%	48%	43%	51%	38%	47%	32%	33%	37%	38%
Zambezia	Molumbo	FY21	Scale Up	29%	55%	83%	88%	69%	61%	51%	56%	38%	91%	84%	97%	70%	80%	71%	67%	72%	76%	63%	73%	57%	50%	56%	59%
Nampula	Moma	FY18	Scale Up Agg	49%	63%	55%	55%	37%	49%	15%	18%	12%	52%	26%	63%	29%	58%	31%	55%	36%	48%	32%	34%	34%	27%	36%	22%
Nampula	Moma	FY19	Scale Up Agg	37%	47%	41%	41%	27%	37%	11%	14%	9%	39%	19%	47%	22%	44%	23%	41%	27%	36%	24%	26%	26%	20%	27%	17%
Nampula	Moma	FY20	Scale Up	47%	58%	56%	58%	41%	53%	28%	35%	23%	54%	34%	62%	41%	62%	38%	58%	43%	50%	35%	38%	39%	29%	45%	26%
Nampula	Moma	FY21	Scale Up	64%	78%	84%	89%	66%	80%	59%	72%	48%	81%	60%	89%	74%	94%	64%	89%	71%	75%	55%	59%	62%	46%	76%	43%
Nampula	Monapo	FY18	Scale Up Agg	42%	40%	51%	45%	33%	36%	22%	29%	13%	33%	18%	47%	22%	48%	30%	46%	34%	39%	29%	37%	31%	26%	37%	21%
Nampula	Monapo	FY19	Scale Up Agg	36%	34%	43%	38%	28%	30%	19%	24%	11%	28%	15%	40%	18%	40%	26%	39%	29%	33%	25%	31%	26%	22%	32%	18%

Nampula	Monapo	FY20	Scale Up	46%	48%	58%	56%	42%	48%	35%	42%	24%	46%	30%	57%	38%	59%	40%	57%	44%	48%	36%	42%	39%	31%	48%	27%
Nampula	Monapo	FY21	Scale Up	64%	70%	84%	88%	66%	79%	62%	75%	49%	78%	57%	88%	73%	93%	65%	88%	72%	74%	55%	62%	62%	47%	78%	44%
Cabo Delgado	Montepuez	FY18	Scale Up Agg	23%	27%	65%	70%	44%	46%	23%	25%	13%	45%	22%	52%	25%	44%	35%	44%	33%	39%	30%	32%	34%	27%	62%	32%
Cabo Delgado	Montepuez	FY19	Scale Up Agg	29%	35%	82%	87%	55%	57%	29%	32%	16%	57%	28%	66%	31%	55%	44%	56%	41%	49%	37%	40%	43%	33%	77%	40%
Cabo Delgado	Montepuez	FY20	Scale Up	43%	48%	97%	101%	69%	74%	42%	50%	24%	74%	38%	77%	40%	67%	55%	68%	51%	57%	47%	49%	50%	43%	80%	46%
Cabo Delgado	Montepuez	FY21	Scale Up	71%	76%	126%	127%	97%	106%	65%	85%	38%	108%	57%	100%	58%	91%	77%	91%	70%	74%	66%	67%	63%	61%	85%	59%
Zambezia	Mopeia	FY18	Scale Up Agg	49%	38%	48%	33%	35%	36%	23%	19%	13%	38%	24%	50%	26%	47%	29%	45%	26%	38%	24%	30%	19%	24%	32%	21%
Zambezia	Mopeia	FY19	Scale Up Agg	38%	29%	37%	25%	27%	28%	18%	14%	10%	29%	19%	39%	20%	36%	23%	35%	20%	30%	19%	23%	15%	18%	25%	16%
Zambezia	Mopeia	FY20	Scale Up	45%	42%	56%	51%	46%	42%	34%	31%	19%	55%	44%	62%	40%	54%	42%	48%	41%	48%	37%	42%	32%	31%	38%	31%
Zambezia	Mopeia	FY21	Scale Up	55%	61%	85%	87%	72%	64%	57%	55%	33%	92%	82%	97%	70%	80%	70%	66%	71%	74%	63%	71%	56%	49%	56%	54%
Zambezia	Morrumbala	FY18	Scale Up Agg	6%	6%	33%	37%	18%	25%	22%	19%	9%	32%	25%	40%	22%	43%	26%	45%	27%	40%	25%	42%	24%	30%	35%	34%
Zambezia	Morrumbala	FY19	Scale Up Agg	5%	5%	28%	31%	16%	21%	19%	16%	8%	27%	21%	34%	19%	36%	22%	38%	23%	34%	21%	36%	21%	26%	29%	29%
Zambezia	Morrumbala	FY20	Scale Up	16%	23%	50%	55%	37%	36%	34%	32%	18%	53%	46%	59%	39%	54%	41%	50%	43%	51%	39%	52%	36%	37%	41%	42%

Zambezia	Morrumbala	FY21	Scale Up	33%	47%	83%	88%	68%	60%	58%	56%	32%	92%	82%	96%	70%	79%	69%	68%	72%	76%	64%	75%	59%	53%	59%	61%
Inhambane	Morrumbene	FY18	Scale Up Agg	13%	43%	52%	51%	74%	88%	74%	47%	26%	21%	8%	32%	10%	41%	16%	57%	23%	65%	27%	69%	22%	56%	90%	94%
Inhambane	Morrumbene	FY19	Sustained	23%	62%	75%	74%	107%	129%	107%	68%	33%	26%	10%	40%	13%	52%	20%	72%	29%	81%	33%	86%	28%	70%	114%	118%
Inhambane	Morrumbene	FY20	Scale Up	36%	71%	91%	90%	107%	129%	107%	69%	49%	53%	32%	61%	32%	65%	40%	76%	48%	82%	50%	87%	37%	71%	114%	118%
Inhambane	Morrumbene	FY21	Scale Up	62%	85%	115%	112%	107%	129%	107%	80%	73%	93%	64%	91%	61%	83%	70%	82%	77%	82%	75%	87%	50%	72%	114%	118%
Nampula	Mossuril	FY18	Sustained	20%	43%	28%	45%	53%	26%	64%	28%	23%	37%	13%	40%	23%	45%	31%	52%	29%	41%	31%	32%	37%	23%	32%	22%
Nampula	Mossuril	FY19	Sustained	11%	24%	15%	25%	29%	14%	35%	15%	12%	20%	7%	22%	13%	25%	17%	29%	16%	22%	17%	18%	20%	13%	18%	12%
Nampula	Mossuril	FY20	Scale Up	25%	39%	38%	47%	43%	35%	48%	36%	26%	40%	24%	44%	34%	49%	33%	49%	34%	39%	29%	31%	34%	23%	38%	22%
Nampula	Mossuril	FY21	Scale Up	50%	65%	76%	86%	67%	74%	70%	72%	49%	75%	54%	84%	71%	92%	61%	86%	67%	70%	51%	54%	59%	41%	73%	40%
Manica	Mossurize	FY18	Scale Up Sat	20%	9%	24%	43%	36%	37%	13%	33%	22%	34%	15%	62%	59%	88%	44%	77%	50%	77%	46%	62%	45%	52%	59%	53%
Manica	Mossurize	FY19	Scale Up Sat	20%	11%	27%	46%	39%	40%	14%	36%	24%	37%	16%	67%	64%	95%	48%	83%	54%	83%	50%	68%	49%	57%	64%	57%
Manica	Mossurize	FY20	Scale Up	48%	43%	61%	76%	61%	63%	33%	51%	39%	51%	32%	76%	71%	96%	57%	86%	62%	86%	58%	73%	55%	63%	68%	62%
Manica	Mossurize	FY21	Scale Up	110%	116%	138%	143%	112%	117%	77%	83%	73%	82%	70%	94%	86%	98%	79%	93%	83%	93%	77%	84%	69%	75%	79%	73%

Sofala	Muanza	FY18	Sustained	12%	14%	27%	31%	21%	24%	13%	16%	11%	20%	14%	33%	21%	43%	30%	48%	30%	37%	22%	29%	17%	25%	31%	43%
Sofala	Muanza	FY19	Sustained	283%	333%	0%	0%	0%	0%	32%	57%	12%	38%	17%	57%	46%	72%	46%	80%	47%	76%	0%	0%	0%	0%	46%	61%
Sofala	Muanza	FY20	Central Support	283%	333%	37%	39%	37%	41%	49%	68%	34%	52%	36%	66%	56%	77%	56%	84%	57%	81%	17%	18%	14%	16%	53%	67%
Sofala	Muanza	FY21	Central Support	283%	333%	116%	121%	118%	128%	87%	93%	85%	78%	76%	82%	78%	86%	76%	91%	79%	90%	56%	59%	44%	51%	69%	83%
Nampula	Mueca te	FY18	Sustained	139%	82%	90%	134%	114%	96%	114%	137%	41%	66%	50%	80%	38%	86%	46%	88%	66%	91%	43%	66%	50%	57%	67%	59%
Nampula	Mueca te	FY19	Scale Up Agg	80%	47%	52%	78%	66%	56%	66%	79%	24%	38%	29%	46%	22%	50%	27%	51%	38%	52%	25%	38%	29%	33%	38%	34%
Nampula	Mueca te	FY20	Scale Up	83%	58%	65%	84%	72%	67%	72%	84%	35%	53%	42%	61%	41%	66%	41%	65%	52%	63%	36%	48%	41%	41%	53%	41%
Nampula	Mueca te	FY21	Scale Up	87%	80%	88%	96%	83%	87%	83%	94%	57%	81%	65%	89%	74%	94%	66%	90%	76%	82%	55%	66%	63%	54%	80%	55%
Cabo Delgado	Mueda	FY18	Scale Up Agg	33%	22%	52%	68%	60%	59%	29%	35%	10%	49%	20%	47%	28%	45%	38%	49%	35%	38%	34%	39%	37%	25%	56%	39%
Cabo Delgado	Mueda	FY19	Scale Up Agg	40%	26%	62%	80%	71%	70%	34%	41%	12%	59%	23%	56%	33%	54%	46%	59%	42%	46%	41%	47%	44%	30%	68%	46%
Cabo Delgado	Mueda	FY20	Scale Up	52%	41%	93%	101%	80%	82%	45%	57%	20%	76%	34%	71%	42%	67%	57%	70%	52%	55%	50%	55%	51%	40%	71%	52%
Cabo Delgado	Mueda	FY21	Scale Up	75%	70%	153%	140%	97%	104%	67%	87%	35%	107%	54%	100%	60%	91%	78%	91%	70%	73%	68%	71%	63%	59%	78%	63%
Niassa	Muembe	FY18	Sustained	12%	15%	22%	26%	21%	26%	15%	19%	11%	19%	12%	28%	16%	33%	22%	37%	25%	35%	23%	33%	22%	28%	33%	40%

Niassa	Muembe	FY19	Sustained	300%	280%	0%	0%	0%	0%	39%	55%	9%	30%	16%	39%	38%	46%	37%	51%	42%	59%	0%	0%	0%	0%	51%	48%
Niassa	Muembe	FY20	Central Support	300%	280%	39%	41%	38%	39%	57%	69%	32%	46%	33%	52%	49%	56%	48%	61%	54%	69%	19%	21%	17%	18%	60%	57%
Niassa	Muembe	FY21	Central Support	300%	280%	110%	121%	113%	113%	91%	95%	73%	75%	63%	73%	67%	74%	67%	78%	74%	84%	57%	63%	49%	55%	74%	72%
Cabo Delgado	Muidumbe	FY18	Scale Up Agg	15%	16%	62%	57%	45%	51%	11%	28%	9%	60%	27%	46%	19%	31%	24%	37%	25%	29%	27%	32%	32%	23%	47%	34%
Cabo Delgado	Muidumbe	FY19	Scale Up Agg	18%	21%	78%	73%	57%	65%	14%	36%	12%	76%	35%	58%	24%	39%	31%	47%	32%	37%	34%	40%	40%	30%	59%	43%
Cabo Delgado	Muidumbe	FY20	Scale Up	35%	37%	96%	101%	70%	79%	29%	53%	20%	86%	44%	72%	34%	55%	45%	61%	43%	48%	44%	49%	48%	40%	64%	49%
Cabo Delgado	Muidumbe	FY21	Scale Up	66%	68%	131%	156%	97%	105%	58%	86%	35%	104%	61%	100%	54%	87%	71%	89%	65%	68%	64%	67%	61%	59%	73%	61%
Zambezia	Mulevala	FY18	Scale Up Agg	51%	40%	42%	52%	18%	20%	14%	16%	8%	31%	31%	63%	31%	49%	29%	40%	30%	46%	27%	41%	16%	18%	23%	22%
Zambezia	Mulevala	FY19	new	50%	39%	41%	51%	17%	19%	13%	16%	8%	31%	30%	62%	30%	47%	28%	39%	29%	45%	26%	40%	16%	18%	22%	21%
Zambezia	Mulevala	FY20	Central Support	56%	50%	59%	67%	38%	36%	30%	32%	17%	56%	52%	76%	48%	62%	46%	51%	47%	59%	42%	55%	32%	30%	36%	36%
Zambezia	Mulevala	FY21	Central Support	67%	67%	87%	91%	68%	59%	55%	55%	31%	92%	84%	98%	74%	83%	72%	68%	74%	80%	66%	77%	57%	48%	55%	57%
Nampula	Murrupula	FY18	Sustained	7%	72%	65%	57%	49%	42%	17%	38%	4%	46%	20%	60%	25%	64%	35%	57%	29%	51%	29%	32%	33%	30%	44%	21%

Nampula	Murrupula	FY19	Sustained	5%	61%	55%	48%	41%	35%	15%	33%	3%	39%	17%	51%	21%	55%	30%	49%	25%	43%	25%	27%	28%	25%	37%	18%
Nampula	Murrupula	FY20	Scale Up	20%	69%	67%	63%	52%	52%	31%	49%	18%	54%	32%	65%	40%	69%	43%	64%	41%	56%	36%	39%	41%	34%	52%	28%
Nampula	Murrupula	FY21	Scale Up	47%	83%	87%	90%	73%	81%	61%	78%	44%	81%	59%	90%	74%	95%	67%	90%	71%	78%	55%	60%	63%	49%	79%	44%
Tete	Mutarara	FY18	Scale Up Agg	0%	0%	48%	49%	37%	33%	19%	15%	16%	29%	23%	82%	35%	120%	59%	91%	63%	88%	51%	48%	20%	32%	27%	28%
Tete	Mutarara	FY19	Scale Up Agg	0%	0%	53%	54%	41%	37%	22%	17%	18%	33%	26%	92%	39%	135%	66%	102%	70%	99%	58%	54%	23%	36%	30%	32%
Tete	Mutarara	FY20	Scale Up	50%	60%	74%	73%	66%	64%	36%	35%	36%	51%	40%	93%	53%	135%	71%	102%	78%	99%	66%	63%	34%	45%	41%	41%
Tete	Mutarara	FY21	Scale Up	75%	83%	114%	108%	114%	115%	60%	66%	68%	77%	65%	93%	71%	135%	81%	102%	92%	100%	82%	80%	58%	62%	60%	56%
Nampula	Nacala	FY18	Scale Up Sat	26%	39%	63%	41%	68%	58%	45%	48%	10%	26%	12%	45%	20%	47%	28%	48%	29%	43%	36%	45%	38%	32%	56%	26%
Nampula	Nacala	FY19	Scale Up Agg	24%	37%	59%	38%	63%	55%	43%	45%	9%	24%	11%	42%	18%	44%	26%	45%	27%	41%	34%	42%	35%	30%	53%	24%
Nampula	Nacala	FY20	Scale Up	36%	50%	70%	56%	70%	66%	54%	58%	23%	43%	27%	59%	38%	62%	40%	61%	43%	54%	43%	52%	47%	38%	64%	33%
Nampula	Nacala	FY21	Scale Up	57%	73%	89%	88%	82%	86%	74%	82%	48%	77%	56%	88%	73%	94%	65%	89%	72%	77%	61%	68%	67%	52%	85%	48%
Nampula	Nacala-A-Velha	FY18	Sustained	27%	13%	43%	83%	51%	86%	18%	32%	7%	37%	19%	71%	29%	68%	35%	57%	37%	44%	40%	38%	49%	27%	41%	19%
Nampula	Nacala-A-Velha	FY19	Sustained	24%	12%	38%	73%	44%	75%	16%	28%	6%	32%	17%	62%	25%	59%	31%	50%	32%	39%	35%	34%	43%	24%	36%	17%

Nampula	Nacala-A-Velha	FY20	Scale Up	36%	30%	54%	81%	55%	81%	32%	45%	21%	49%	32%	73%	43%	72%	44%	64%	47%	52%	44%	44%	53%	32%	52%	26%
Nampula	Nacala-A-Velha	FY21	Scale Up	59%	65%	84%	95%	73%	92%	62%	78%	46%	79%	59%	92%	75%	95%	68%	90%	74%	76%	61%	63%	71%	48%	79%	43%
Nampula	Nacaroa	FY18	Sustained	39%	39%	50%	67%	47%	55%	17%	27%	24%	59%	36%	79%	46%	84%	44%	65%	56%	55%	36%	35%	21%	26%	21%	15%
Nampula	Nacaroa	FY19	Sustained	29%	29%	37%	49%	35%	40%	13%	20%	18%	44%	26%	58%	34%	62%	33%	48%	41%	41%	26%	26%	15%	19%	15%	11%
Nampula	Nacaroa	FY20	Scale Up	40%	43%	54%	64%	47%	55%	30%	39%	30%	58%	40%	70%	50%	74%	46%	63%	54%	54%	37%	38%	30%	28%	36%	21%
Nampula	Nacaroa	FY21	Scale Up	57%	71%	83%	91%	70%	82%	61%	73%	53%	83%	63%	91%	78%	96%	68%	90%	77%	77%	56%	59%	56%	45%	72%	39%
Maputo	Namaacha	FY18	Scale Up Sat	28%	23%	43%	36%	55%	70%	71%	47%	32%	41%	22%	51%	17%	45%	39%	66%	46%	68%	45%	68%	44%	45%	58%	56%
Maputo	Namaacha	FY19	Scale Up Agg	31%	25%	46%	39%	58%	74%	76%	50%	35%	44%	23%	55%	18%	49%	41%	71%	50%	72%	48%	72%	48%	48%	62%	60%
Maputo	Namaacha	FY20	Scale Up	35%	30%	50%	44%	61%	76%	78%	56%	52%	58%	32%	63%	27%	57%	52%	74%	58%	75%	58%	75%	55%	52%	66%	62%
Maputo	Namaacha	FY21	Scale Up	46%	42%	60%	57%	66%	80%	84%	70%	93%	90%	52%	82%	46%	76%	76%	82%	77%	81%	83%	82%	71%	62%	75%	65%
Zambezia	Namacurra	FY18	Scale Up Agg	47%	64%	75%	74%	71%	78%	29%	41%	22%	56%	41%	72%	40%	54%	40%	52%	32%	42%	29%	36%	29%	24%	35%	25%
Zambezia	Namacurra	FY19	Scale Up Agg	54%	75%	86%	85%	81%	90%	33%	47%	25%	65%	47%	82%	46%	62%	46%	60%	37%	48%	34%	41%	33%	28%	40%	29%
Zambezia	Namacurra	FY20	Scale Up	59%	79%	90%	90%	86%	92%	46%	57%	33%	77%	64%	89%	60%	72%	60%	68%	53%	62%	48%	56%	46%	39%	51%	42%

Zambezia	Namacurra	FY21	Scale Up	67%	85%	97%	97%	93%	95%	65%	72%	45%	96%	88%	99%	80%	88%	79%	79%	77%	81%	70%	78%	65%	55%	66%	61%
Zambezia	Namaroi	FY18	Scale Up Agg	20%	82%	22%	44%	30%	21%	8%	0%	16%	21%	25%	34%	21%	48%	32%	48%	24%	49%	24%	27%	22%	28%	27%	14%
Zambezia	Namaroi	FY19	Sustained	29%	112%	29%	62%	43%	29%	12%	0%	25%	33%	40%	55%	34%	77%	51%	76%	38%	79%	38%	44%	35%	45%	43%	22%
Zambezia	Namaroi	FY20	Central Support	38%	112%	51%	75%	57%	43%	29%	19%	33%	57%	59%	72%	50%	83%	63%	81%	54%	84%	52%	58%	48%	53%	53%	36%
Zambezia	Namaroi	FY21	Central Support	53%	112%	83%	94%	78%	64%	53%	48%	44%	93%	87%	97%	76%	93%	81%	88%	77%	92%	72%	78%	66%	65%	67%	57%
Nampula	Nampula	FY18	Scale Up Agg	30%	32%	66%	70%	81%	92%	77%	89%	15%	26%	8%	39%	14%	44%	24%	51%	29%	49%	35%	49%	45%	44%	68%	43%
Nampula	Nampula	FY19	Scale Up Sat	32%	35%	72%	76%	89%	100%	84%	97%	16%	28%	9%	43%	15%	48%	26%	56%	31%	54%	38%	54%	49%	48%	74%	47%
Nampula	Nampula	FY20	Scale Up	43%	48%	79%	83%	91%	100%	87%	97%	29%	46%	25%	59%	35%	65%	40%	69%	46%	64%	47%	61%	58%	54%	80%	53%
Nampula	Nampula	FY21	Scale Up	62%	72%	92%	95%	94%	100%	93%	99%	52%	78%	55%	88%	72%	94%	66%	91%	73%	82%	63%	74%	74%	65%	92%	64%
Cabo Delgado	Namuno	FY18	Sustained	19%	20%	22%	23%	9%	11%	3%	9%	7%	33%	16%	38%	20%	34%	29%	39%	25%	25%	20%	19%	20%	14%	21%	14%
Cabo Delgado	Namuno	FY19	Sustained	30%	32%	35%	36%	15%	18%	6%	15%	12%	53%	26%	61%	31%	54%	47%	62%	39%	41%	31%	30%	32%	22%	34%	22%
Cabo Delgado	Namuno	FY20	Scale Up	44%	46%	88%	103%	41%	50%	22%	37%	20%	72%	36%	74%	41%	67%	58%	72%	49%	51%	42%	41%	40%	33%	42%	30%
Cabo Delgado	Namuno	FY21	Scale Up	70%	73%	191%	230%	93%	111%	53%	81%	36%	109%	56%	100%	58%	90%	78%	92%	69%	70%	62%	61%	56%	54%	56%	46%

Cabo Delgado	Nangade	FY18	Sustained	10%	0%	37%	18%	25%	28%	11%	16%	3%	25%	4%	23%	12%	28%	18%	31%	19%	27%	20%	29%	21%	16%	30%	20%
Cabo Delgado	Nangade	FY19	Sustained	13%	0%	50%	24%	34%	39%	16%	23%	4%	33%	5%	31%	17%	38%	24%	41%	26%	37%	27%	39%	28%	22%	40%	27%
Cabo Delgado	Nangade	FY20	Scale Up	30%	20%	91%	103%	54%	63%	30%	43%	13%	60%	18%	54%	28%	55%	39%	57%	38%	47%	38%	49%	36%	33%	47%	35%
Cabo Delgado	Nangade	FY21	Scale Up	63%	63%	171%	255%	94%	109%	59%	82%	29%	112%	43%	100%	49%	87%	68%	88%	62%	68%	60%	67%	53%	54%	60%	50%
Niassa	Ngauma	FY18	Sustained	0%	14%	7%	19%	18%	18%	19%	10%	8%	16%	8%	13%	16%	28%	14%	34%	21%	32%	16%	32%	30%	22%	29%	22%
Niassa	Ngauma	FY19	Sustained	0%	17%	9%	22%	21%	21%	23%	11%	9%	17%	9%	15%	18%	31%	16%	38%	24%	35%	18%	36%	34%	25%	33%	24%
Niassa	Ngauma	FY20	Scale Up		51%	44%	54%	51%	51%	46%	39%	32%	37%	28%	33%	33%	44%	31%	50%	39%	50%	33%	50%	45%	39%	45%	37%
Niassa	Ngauma	FY21	Scale Up		92%	111%	117%	109%	112%	87%	89%	75%	71%	60%	63%	56%	67%	57%	73%	66%	76%	65%	77%	67%	66%	65%	60%
Sofala	Nhamatanda	FY18	Scale Up Agg	15%	29%	54%	54%	35%	49%	25%	31%	13%	25%	16%	54%	31%	65%	40%	67%	41%	54%	32%	44%	31%	32%	39%	39%
Sofala	Nhamatanda	FY19	Scale Up Sat	16%	29%	55%	55%	36%	50%	25%	32%	13%	25%	16%	55%	31%	66%	41%	68%	42%	55%	33%	44%	31%	32%	39%	39%
Sofala	Nhamatanda	FY20	Scale Up	39%	50%	72%	73%	59%	71%	44%	49%	36%	41%	35%	64%	44%	72%	52%	73%	53%	63%	45%	55%	41%	43%	47%	50%
Sofala	Nhamatanda	FY21	Scale Up	84%	87%	107%	110%	111%	114%	86%	88%	84%	73%	75%	81%	72%	84%	74%	85%	77%	82%	70%	77%	62%	67%	65%	73%
Zambezia	Nicoadala	FY18	Scale Up Agg	50%	54%	64%	74%	46%	64%	32%	38%	18%	63%	42%	81%	40%	51%	35%	47%	31%	39%	24%	35%	26%	27%	33%	25%

Zambezia	Nicoadala	FY19	Scale Up Agg	66%	71%	83%	96%	61%	84%	42%	50%	23%	82%	54%	106%	52%	66%	45%	61%	41%	51%	31%	46%	33%	35%	43%	32%
Zambezia	Nicoadala	FY20	Scale Up	70%	77%	88%	97%	70%	87%	53%	60%	31%	89%	69%	106%	64%	75%	59%	69%	56%	63%	46%	59%	47%	45%	53%	44%
Zambezia	Nicoadala	FY21	Scale Up	76%	84%	96%	99%	85%	92%	69%	74%	43%	98%	90%	106%	82%	89%	79%	80%	78%	82%	68%	79%	66%	59%	67%	63%
Niassa	Nipepe	FY18	Sustained	16%	0%	18%	33%	4%	11%	8%	8%	9%	17%	29%	36%	19%	36%	25%	39%	24%	23%	13%	16%	8%	5%	14%	4%
Niassa	Nipepe	FY19	Sustained	17%	0%	23%	38%	4%	15%	8%	8%	10%	20%	35%	43%	22%	43%	29%	46%	29%	27%	16%	19%	9%	6%	16%	5%
Niassa	Nipepe	FY20	Central Support	57%	41%	53%	64%	40%	48%	35%	37%	32%	39%	48%	54%	36%	54%	42%	56%	43%	44%	32%	36%	24%	23%	31%	21%
Niassa	Nipepe	FY21	Central Support	100%	83%	109%	114%	112%	112%	84%	88%	76%	72%	71%	75%	59%	73%	63%	76%	69%	73%	64%	71%	55%	57%	57%	50%
Cidade De Maputo	Nlhamankulu	FY18	Scale Up Sat	46%	82%	82%	117%	166%	190%	169%	167%	131%	138%	64%	124%	84%	121%	119%	152%	140%	153%	117%	120%	106%	78%	120%	65%
Cidade De Maputo	Nlhamankulu	FY19	Scale Up Sat	50%	88%	82%	119%	166%	192%	170%	168%	132%	140%	65%	125%	85%	122%	120%	153%	141%	155%	118%	121%	107%	79%	122%	66%
Cidade De Maputo	Nlhamankulu	FY20	Scale Up	69%	94%	94%	119%	166%	192%	170%	168%	132%	140%	79%	125%	94%	122%	120%	153%	141%	155%	118%	121%	107%	81%	122%	80%
Cidade De Maputo	Nlhamankulu	FY21	Scale Up	83%	100%	103%	119%	166%	192%	170%	168%	132%	140%	89%	125%	100%	122%	120%	153%	141%	155%	118%	121%	107%	83%	122%	91%
Cabo Delgado	Palma	FY18	Sustained	11%	20%	27%	55%	36%	29%	18%	25%	3%	18%	6%	23%	14%	28%	19%	40%	17%	32%	25%	27%	22%	22%	33%	20%
Cabo Delgado	Palma	FY19	Sustained	10%	20%	30%	62%	40%	33%	20%	27%	3%	19%	6%	24%	15%	30%	20%	43%	18%	35%	26%	29%	24%	23%	35%	22%

Cabo Delgado	Palma	FY20	Scale Up	28%	36%	87%	102%	59%	59%	34%	46%	12%	52%	19%	50%	26%	49%	36%	58%	32%	46%	38%	40%	33%	34%	42%	30%
Cabo Delgado	Palma	FY21	Scale Up	60%	70%	197%	176%	96%	109%	60%	84%	28%	114%	43%	100%	48%	86%	67%	88%	58%	67%	60%	61%	50%	55%	56%	46%
Inhambane	Panda	FY18	Sustained	0%	0%	74%	132%	157%	99%	75%	60%	0%	35%	6%	43%	10%	46%	23%	71%	32%	102%	33%	91%	26%	79%	106%	103%
Inhambane	Panda	FY19	Sustained	0%	0%	82%	148%	171%	111%	82%	67%	0%	37%	7%	44%	10%	48%	24%	73%	33%	105%	34%	94%	27%	82%	109%	107%
Inhambane	Panda	FY20	Scale Up	17%	25%	94%	148%	171%	111%	82%	68%	24%	60%	29%	64%	30%	62%	43%	77%	52%	105%	50%	94%	36%	82%	109%	107%
Inhambane	Panda	FY21	Scale Up	40%	60%	109%	148%	171%	111%	82%	78%	59%	94%	62%	92%	60%	82%	72%	83%	79%	105%	75%	94%	50%	83%	109%	107%
Zambezia	Pebane	FY18	Scale Up Agg	33%	49%	68%	85%	47%	70%	20%	26%	13%	57%	44%	86%	39%	66%	40%	62%	38%	48%	30%	40%	30%	29%	38%	45%
Zambezia	Pebane	FY19	Scale Up Agg	34%	51%	70%	88%	49%	72%	20%	27%	13%	59%	45%	89%	40%	69%	42%	64%	40%	50%	31%	42%	31%	30%	40%	46%
Zambezia	Pebane	FY20	Scale Up	42%	61%	79%	92%	62%	78%	36%	41%	22%	74%	62%	93%	55%	77%	56%	71%	55%	63%	47%	56%	45%	40%	50%	56%
Zambezia	Pebane	FY21	Scale Up	54%	74%	93%	98%	80%	86%	58%	62%	36%	95%	88%	99%	78%	90%	77%	82%	78%	82%	69%	78%	64%	56%	65%	71%
Cabo Delgado	Pemba	FY18	Sustained	28%	32%	64%	63%	76%	87%	48%	53%	15%	25%	13%	36%	15%	39%	27%	46%	33%	46%	39%	46%	51%	45%	90%	58%
Cabo Delgado	Pemba	FY19	Scale Up Agg	32%	35%	72%	72%	85%	98%	54%	60%	17%	28%	14%	40%	17%	44%	30%	52%	37%	51%	44%	51%	57%	51%	102%	65%
Cabo Delgado	Pemba	FY20	Scale Up	45%	49%	95%	101%	90%	99%	62%	71%	24%	57%	26%	61%	28%	59%	44%	65%	47%	60%	52%	59%	62%	58%	102%	69%

Cabo Delgado	Pemba	FY21	Scale Up	72%	75%	139%	158%	99%	100%	77%	91%	39%	113%	49%	100%	50%	88%	71%	90%	67%	76%	69%	73%	72%	71%	102%	76%
Zambezia	Quelimane	FY18	Scale Up Agg	23%	37%	74%	82%	82%	105%	57%	76%	30%	47%	38%	71%	35%	63%	40%	66%	38%	57%	39%	55%	38%	42%	59%	53%
Zambezia	Quelimane	FY19	Scale Up Agg	26%	40%	81%	92%	90%	115%	63%	84%	33%	53%	43%	80%	39%	71%	45%	74%	43%	64%	44%	61%	42%	47%	66%	59%
Zambezia	Quelimane	FY20	Scale Up Sat	35%	51%	87%	94%	92%	115%	70%	87%	40%	70%	61%	88%	54%	79%	59%	79%	58%	73%	56%	71%	54%	55%	72%	67%
Zambezia	Quelimane	FY21	Scale Up	48%	67%	96%	99%	96%	115%	81%	91%	51%	95%	87%	99%	77%	91%	79%	86%	79%	87%	74%	85%	70%	67%	80%	78%
Cabo Delgado	Quissanga	FY18	Sustained	22%	22%	85%	45%	40%	43%	5%	34%	0%	18%	7%	37%	15%	32%	24%	36%	20%	30%	20%	25%	35%	15%	31%	19%
Cabo Delgado	Quissanga	FY19	Sustained	25%	25%	100%	57%	50%	53%	6%	44%	0%	21%	7%	44%	19%	38%	29%	44%	24%	36%	24%	30%	42%	18%	37%	24%
Cabo Delgado	Quissanga	FY20	Central Support	40%	40%	100%	102%	66%	71%	22%	59%	9%	53%	20%	63%	30%	55%	43%	59%	36%	47%	36%	41%	49%	29%	44%	32%
Cabo Delgado	Quissanga	FY21	Central Support	75%	75%	100%	186%	94%	106%	53%	88%	25%	114%	45%	100%	51%	87%	71%	88%	60%	68%	59%	62%	62%	51%	58%	48%
Nampula	Rapale	FY18	Sustained	49%	31%	45%	63%	43%	44%	27%	39%	13%	44%	16%	50%	17%	52%	33%	56%	31%	43%	30%	37%	41%	28%	44%	24%
Nampula	Rapale	FY19	Scale Up Agg	42%	28%	39%	56%	38%	39%	23%	34%	11%	38%	14%	44%	15%	46%	29%	49%	27%	37%	26%	33%	36%	25%	39%	21%
Nampula	Rapale	FY20	Scale Up	51%	43%	55%	69%	50%	54%	38%	50%	25%	54%	29%	60%	35%	63%	42%	64%	43%	51%	37%	43%	47%	33%	53%	30%
Nampula	Rapale	FY21	Scale Up	68%	67%	84%	92%	71%	81%	64%	79%	49%	81%	57%	89%	71%	94%	67%	90%	71%	75%	56%	63%	67%	49%	80%	46%

Nampula	Ribaue	FY18	Scale Up Agg	10%	36%	53%	54%	33%	62%	27%	51%	11%	44%	15%	58%	20%	54%	29%	61%	31%	39%	38%	37%	30%	26%	37%	16%
Nampula	Ribaue	FY19	Sustained	8%	29%	43%	44%	27%	50%	22%	41%	9%	35%	12%	47%	16%	43%	23%	49%	25%	31%	31%	30%	24%	21%	30%	13%
Nampula	Ribaue	FY20	Scale Up	23%	44%	58%	60%	41%	62%	37%	55%	23%	52%	28%	62%	36%	62%	38%	64%	41%	46%	41%	41%	37%	30%	47%	23%
Nampula	Ribaue	FY21	Scale Up	50%	71%	85%	90%	65%	84%	65%	80%	47%	80%	56%	89%	72%	94%	64%	90%	71%	73%	59%	61%	61%	46%	77%	41%
Niassa	Sanga	FY18	Sustained	8%	10%	16%	18%	15%	18%	11%	14%	8%	14%	8%	19%	11%	23%	16%	26%	18%	25%	16%	23%	15%	18%	19%	24%
Niassa	Sanga	FY19	Sustained	209%	182%	0%	0%	0%	0%	27%	36%	9%	20%	11%	25%	26%	30%	26%	34%	29%	39%	0%	0%	0%	0%	30%	27%
Niassa	Sanga	FY20	Central Support	209%	182%	39%	41%	38%	39%	49%	56%	32%	39%	29%	41%	40%	43%	39%	47%	43%	53%	19%	21%	17%	18%	43%	39%
Niassa	Sanga	FY21	Central Support	209%	182%	112%	121%	112%	116%	88%	91%	73%	72%	61%	67%	61%	66%	62%	71%	69%	77%	57%	63%	50%	54%	64%	62%
Manica	Sussundenga	FY18	Scale Up Sat	8%	24%	59%	80%	35%	42%	20%	20%	11%	45%	24%	81%	51%	99%	60%	84%	48%	64%	40%	43%	39%	23%	43%	41%
Manica	Sussundenga	FY19	Scale Up Agg	5%	20%	58%	77%	33%	40%	19%	19%	11%	43%	23%	78%	49%	95%	58%	81%	46%	62%	38%	41%	38%	22%	42%	40%
Manica	Sussundenga	FY20	Scale Up	38%	49%	78%	90%	57%	63%	37%	37%	28%	56%	38%	84%	59%	96%	66%	84%	56%	68%	48%	51%	45%	33%	49%	47%
Manica	Sussundenga	FY21	Scale Up	110%	115%	122%	119%	113%	116%	78%	79%	69%	84%	73%	96%	80%	98%	83%	92%	80%	84%	71%	71%	62%	55%	66%	62%
Manica	Tambara	FY18	Sustained	97%	0%	102%	54%	26%	56%	24%	63%	44%	55%	44%	58%	102%	112%	32%	60%	37%	64%	70%	58%	58%	60%	98%	48%

Manica	Tambara	FY19	Sustained	100%	0%	105%	56%	27%	57%	25%	62%	45%	55%	43%	58%	102%	112%	32%	61%	37%	65%	69%	58%	59%	60%	99%	48%
Manica	Tambara	FY20	Central Support	100%		105%	80%	53%	74%	41%	70%	56%	65%	54%	68%	102%	112%	44%	67%	49%	71%	74%	65%	64%	65%	99%	54%
Manica	Tambara	FY21	Central Support	100%		105%	133%	114%	111%	80%	90%	82%	87%	80%	93%	102%	112%	74%	84%	77%	86%	86%	80%	75%	77%	99%	67%
Tete	Tete	FY18	Scale Up Sat	21%	35%	59%	59%	66%	74%	31%	43%	46%	60%	38%	111%	52%	103%	73%	100%	76%	81%	53%	53%	45%	38%	52%	42%
Tete	Tete	FY19	Scale Up Sat	24%	36%	60%	61%	68%	76%	32%	44%	48%	62%	39%	114%	53%	105%	75%	103%	78%	84%	55%	55%	46%	39%	54%	43%
Tete	Tete	FY20	Scale Up Sat	62%	74%	78%	77%	82%	87%	44%	57%	59%	72%	51%	114%	63%	105%	79%	103%	83%	87%	63%	63%	54%	48%	61%	51%
Tete	Tete	FY21	Scale Up	83%	91%	112%	106%	107%	106%	65%	77%	79%	87%	71%	114%	78%	105%	86%	103%	94%	92%	81%	81%	71%	64%	73%	64%
Tete	Tsangano	FY18	Sustained	37%	45%	57%	67%	37%	44%	18%	22%	15%	50%	34%	93%	52%	90%	65%	90%	60%	72%	43%	51%	31%	34%	34%	44%
Tete	Tsangano	FY19	Sustained	917%	867%	0%	0%	0%	0%	46%	65%	14%	78%	44%	132%	119%	124%	105%	124%	98%	122%	0%	0%	0%	0%	52%	53%
Tete	Tsangano	FY20	Central Support	917%	867%	45%	41%	43%	43%	56%	72%	33%	84%	55%	132%	119%	124%	105%	124%	98%	122%	19%	19%	15%	14%	59%	59%
Tete	Tsangano	FY21	Central Support	917%	867%	129%	115%	124%	124%	71%	85%	67%	92%	74%	132%	119%	124%	105%	124%	99%	122%	57%	58%	45%	40%	72%	70%
Manica	Vanduzi	FY18	Sustained	27%	45%	73%	70%	43%	58%	21%	31%	23%	42%	21%	82%	38%	94%	63%	86%	49%	63%	42%	49%	39%	29%	60%	46%

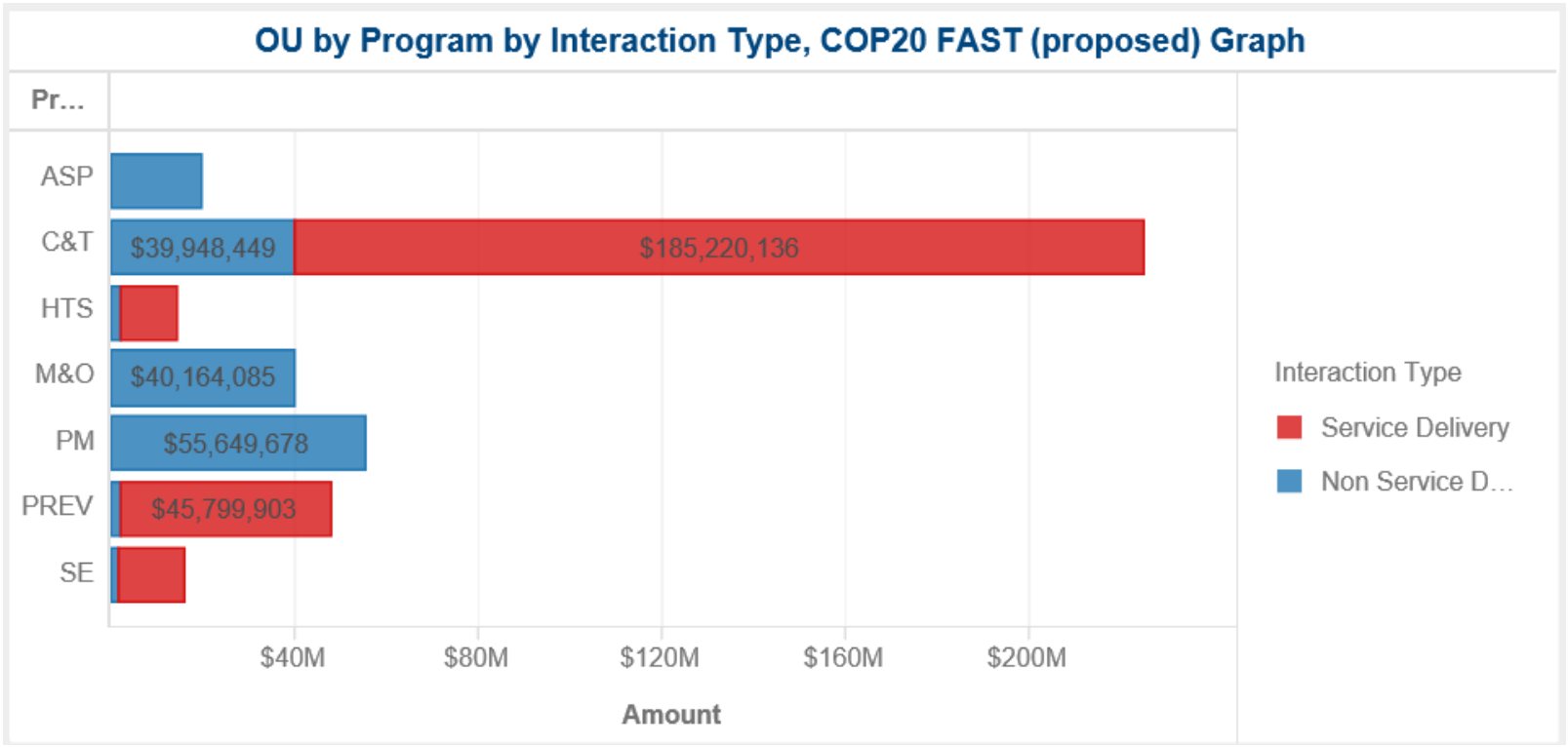
Manica	Vanduzi	FY19	new	24%	35%	59%	58%	35%	47%	18%	25%	19%	34%	18%	67%	31%	77%	52%	71%	40%	52%	35%	40%	32%	24%	49%	37%
Manica	Vanduzi	FY20	Scale Up	50%	58%	78%	81%	59%	68%	36%	41%	35%	49%	34%	75%	45%	81%	61%	75%	51%	60%	45%	50%	40%	34%	55%	44%
Manica	Vanduzi	FY21	Scale Up	106%	112%	121%	133%	113%	114%	77%	80%	72%	81%	71%	94%	74%	91%	81%	88%	78%	80%	69%	71%	59%	56%	70%	60%
Inhambane	Vilankulo	FY18	Scale Up Agg	17%	19%	70%	54%	84%	88%	83%	104%	39%	64%	15%	58%	20%	59%	33%	77%	39%	85%	44%	67%	42%	75%	107%	90%
Inhambane	Vilankulo	FY19	Scale Up Sat	17%	19%	78%	60%	93%	97%	92%	116%	39%	66%	15%	60%	21%	61%	34%	80%	41%	88%	45%	69%	44%	78%	110%	93%
Inhambane	Vilankulo	FY20	Scale Up	31%	39%	92%	85%	94%	98%	92%	116%	54%	79%	35%	74%	38%	71%	51%	82%	57%	88%	59%	70%	51%	78%	110%	94%
Inhambane	Vilankulo	FY21	Scale Up	57%	67%	113%	118%	95%	98%	92%	116%	76%	97%	65%	94%	64%	87%	76%	87%	81%	88%	79%	70%	62%	79%	110%	97%
Gaza	Xai-Xai	FY18	Scale Up Agg	42%	35%	73%	95%	104%	130%	98%	108%	69%	60%	24%	64%	24%	67%	34%	84%	43%	95%	50%	96%	46%	95%	132%	130%
Gaza	Xai-Xai	FY19	Scale Up Sat	42%	35%	74%	97%	105%	132%	99%	110%	69%	61%	24%	65%	24%	68%	35%	85%	43%	96%	50%	98%	47%	97%	134%	132%
Gaza	Xai-Xai	FY20	Scale Up	61%	57%	108%	102%	105%	132%	99%	110%	75%	69%	40%	92%	43%	81%	52%	87%	56%	96%	60%	98%	53%	97%	134%	132%
Gaza	Xai-Xai	FY21	Scale Up	92%	91%	161%	111%	105%	132%	99%	110%	85%	82%	66%	135%	75%	100%	81%	88%	77%	97%	77%	98%	64%	97%	134%	132%
Inhambane	Zavala	FY18	Scale Up Agg	8%	29%	84%	61%	106%	122%	69%	82%	32%	47%	9%	52%	11%	61%	20%	74%	30%	78%	38%	82%	33%	68%	110%	122%
Inhambane	Zavala	FY19	Scale Up Sat	13%	33%	92%	67%	116%	134%	75%	89%	34%	50%	10%	55%	11%	64%	21%	78%	32%	82%	41%	87%	35%	71%	116%	128%

Inhambane	Zavala	FY20	Scale Up	27%	50%	97%	88%	116%	134%	75%	90%	50%	68%	31%	70%	31%	74%	41%	81%	50%	82%	55%	87%	43%	72%	116%	128%
Inhambane	Zavala	FY21	Scale Up	50%	73%	106%	115%	116%	134%	76%	93%	73%	95%	63%	93%	60%	88%	71%	86%	78%	82%	78%	87%	56%	73%	116%	128%
Tete	Zumbu	FY18	Attained	12%	14%	20%	23%	12%	14%	6%	8%	6%	20%	14%	42%	24%	47%	26%	42%	22%	34%	15%	25%	12%	17%	14%	24%
Tete	Zumbu	FY19	Sustained	340%	260%	0%	0%	0%	0%	19%	21%	8%	30%	21%	58%	65%	63%	51%	56%	42%	56%	0%	0%	0%	0%	26%	28%
Tete	Zumbu	FY20	Central Support	340%	260%	45%	41%	43%	43%	33%	38%	28%	49%	37%	62%	73%	63%	59%	56%	56%	64%	19%	19%	15%	14%	37%	38%
Tete	Zumbu	FY21	Central Support	340%	260%	129%	114%	124%	124%	57%	68%	64%	75%	64%	65%	84%	68%	73%	71%	85%	78%	57%	58%	45%	40%	57%	54%

APPENDIX B – Budget Profile and Resource Projections

COP20 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP20 Budget by Program Area



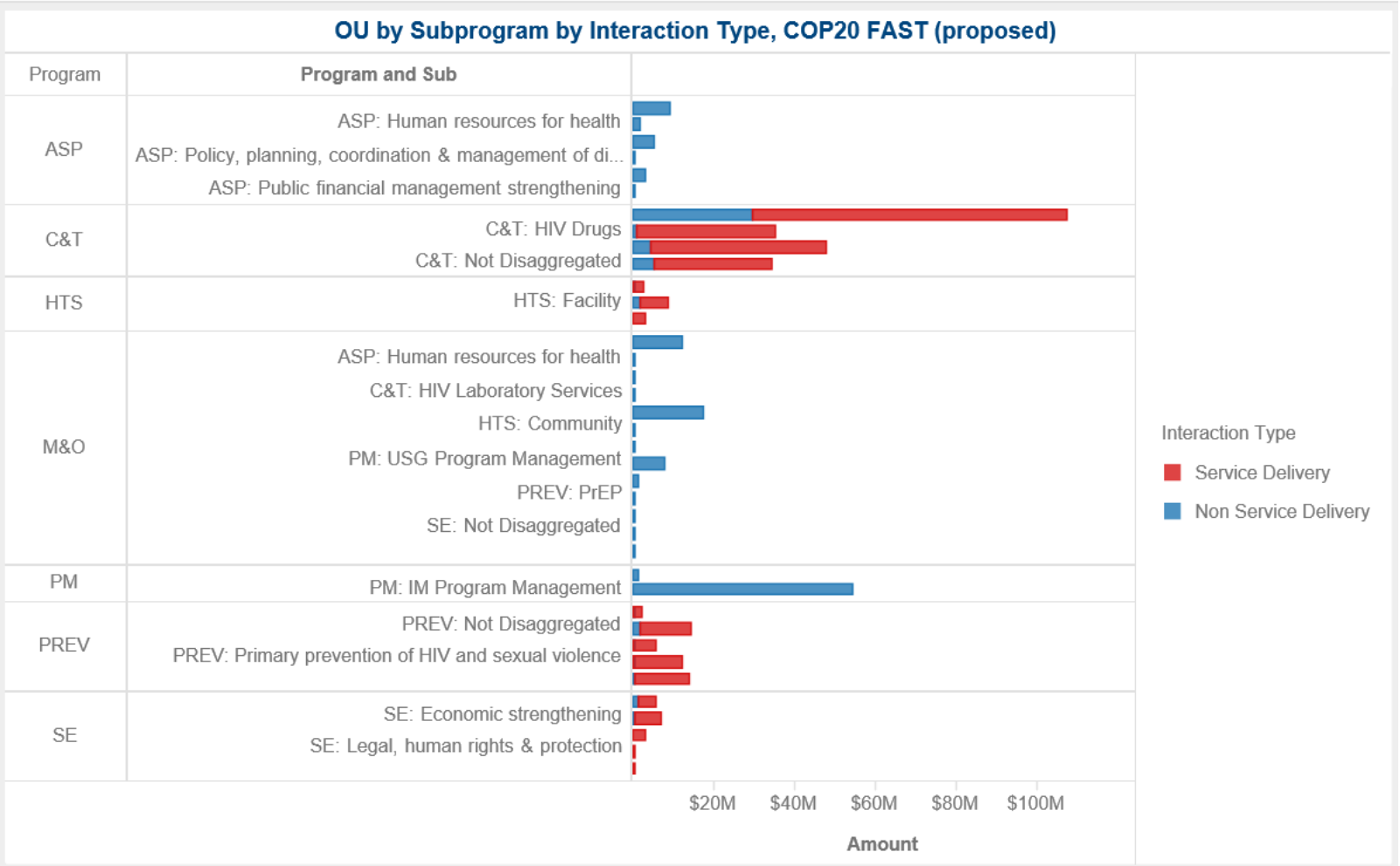


Table B.1.2 COP20 Total Planning Level			
Funding Agency	**Applied Pipeline**	**New Funding**	**Total Spend**
DOD	$84,151	$7,801,584	$7,885,735
HHS/CDC	$31,222,132	$157,003,521	$188,225,653

HHS/HRSA	$-	$4,274,256	$4,274,256
HHS/SAMHSA	$-	$-	$-
PC	$549,266	$2,542,955	$3,092,221
State	$-	$7,921,716	$7,921,716
USAID	$8,799,268	$198,664,839	$207,464,107
TOTAL	**$40,654,817**	**$378,208,871**	**$418,863,688**

*Data included in Table B.1.2 should match FACTS Info records and total applied pipeline amount required in PLL guidance.

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)			
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**	**% Allocated**
CIRC	Male Circumcision	$11,466,359	3%
HBHC	Adult Care and Support	$-	0%
HKID	Orphans and Vulnerable Children	$18,637,860	5%
HLAB	Lab	$5,366,861	1%
HMBL	Blood Safety	$-	0%
HMIN	Injection Safety	$-	0%
HTXD	ARV Drugs	$30,407,658	8%
HTXS	Adult Treatment	$194,685,273	52%
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$14,006,254	4%
HVCT	Counseling and Testing	$10,066,678	3%

HVMS	Management and Operations	$17,317,663	5%
HVOP	Other Sexual Prevention	$23,820,373	6%
HVSI	Strategic Information	$7,414,371	2%
HVTB	TB/HIV Care	$9,304,999	2%
IDUP	Injecting and Non-Injecting Drug Use	$24,771	0%
MTCT	Mother to Child Transmission	$2,987,041	1%
OHSS	Health Systems Strengthening	$5,009,462	1%
PDCS	Pediatric Care and Support	$14,837,485	4%
PDTX	Pediatric Treatment	$11,355,765	3%
TOTAL		**$376,708,873**	**100%**

*Data included in Table B.2.2 should match FACTS Info records.

B.2 Resource Projections

PEPFAR Mozambique took a methodical approach to planning the investment of additional COP20 funds. The OU maintained budget efficiencies identified through the 16% budget decrease in COP19 and planned the allocation of the $117,200,000 of Planning Level Letter directives. These two exercises left $67,110,400 within the approved COP20 funding envelope to be strategically allocated towards programs and interventions that fill key gaps for epidemic control, including viral load and EID commodities, service delivery innovations (mental health, youth case management, advanced disease, etc.), private sector engagement in specimen transport and medicines distribution, and health informatics. Interagency Technical Working Groups costed these interventions and analyzed data to identify those that were likeliest to address identified barriers, particularly with men and young women, while fitting within the budget envelope. Close coordination with GRM during this process ensured selection of approaches that aligned with national priorities.

To reduce potential duplication, the USG team coordinated closely with GRM and Global Fund to identify programs and commodities that are likely to be included in the upcoming Global Fund application.

In consultation with GRM, USG expanded the COP19 efforts fund program areas where clinical partners are transitioning responsibility to provincial government health institutions. Funding to central level host government institutions was maintained, to ensure they can continue their critical stewardship of Mozambique's epidemic control.

APPENDIX C – Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	Program Area	COP20 Beneficiary	Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
HHS/CDC	Vanderbilt University Medical Center	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Inadequate commodity data collection at the national/sub-national level and at the facility level	COP19	COP22	4 releases
DOD	JHPIEGO CORPORATION	ASP: Laboratory systems strengthening-NSD	Priority Pops: Military & other uniformed services	Lab quality improvement and assurance	Lack of appropriate lab data systems needed for scaling up quality VL, EID and/or TB testing	COP18	COP22	80% HF
HHS/CDC	INTERNATION ORGANIZATION FOR MIGRATION	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Evaluations	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP20	COP20	data collection system implemented
HHS/CDC	Vanderbilt University Medical Center	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP18	COP22	4 releases
HHS/CDC	Vanderbilt University Medical Center	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP19	COP22	1

HHS/CDC	Vanderbilt University Medical Center	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP20	COP22	1
HHS/CDC	FUNDACAO ARIEL CONTRA A SIDA PEDIATRICA	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP18	COP22	400 users
HHS/CDC	Vanderbilt University Medical Center	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP20	COP22	1000 registered
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP20	COP22	1000 patients uniquely identified and reported
USAID	Management Systems International, Inc.	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP20	COP22	55 Health Facilty DQAs completed + a Final report completed by December 31, 2021

HHS/CDC	MINISTRY OF HEALTH, MOZAMBIQUE	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	MR - Inefficient, non-client friendly service delivery models	COP20	COP22	20 Provincial and District MOH staff participating in DQAs
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP19	COP22	One round of surveillance completed
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP18	COP21	20
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP18	COP21	20
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP20	COP20	5

HHS/CDC	Vanderbilt University Medical Center	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Lack of appropriate lab data systems needed for scaling up quality VL, EID and/or TB testing	COP19	COP22	1
HHS/CDC	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Adults	Program and data quality management	Insufficient HIV estimates to inform program planning	COP20	COP20	National, provincial, and district PLHIV estimates produced
HHS/CDC	Association of Public Health Laboratories, Inc. (THE)	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Lack of appropriate lab data systems needed for scaling up quality VL, EID and/or TB testing	COP16	COP22	DISA Lab installations maintained
HHS/CDC	Association of Public Health Laboratories, Inc. (THE)	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Lack of appropriate lab data systems needed for scaling up quality VL, EID and/or TB testing	COP19	COP21	DISA EPTS intergration implemented in three provinces
HHS/CDC	Association of Public Health Laboratories, Inc. (THE)	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Lack of appropriate lab data systems needed for scaling up quality VL, EID and/or TB testing	COP19	COP21	50% of mPIMA instruments transferring EID testing data to open LDR
HHS/CDC	Association of Public Health Laboratories, Inc. (THE)	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Lack of appropriate lab data systems needed for scaling up quality VL, EID and/or TB testing	COP17	COP22	95% of district hubs (AJUDA) and 100% of health facilities with >2000 patients on ART with DISA link installed
HHS/CDC	Association of Public Health Laboratories, Inc. (THE)	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab accreditation	Critical lab systems essential for scaling up quality VL, EID and/or TB testing	COP16	COP22	3 VL and 6 reference labs accredited, >70% of provincial and VL labs with at least > 3 star on SLMTA checklist

HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate laboratory quality management systems to guarantee efficient laboratory process for accurate and reliable results	COP16	COP22	3 VL and 6 reference labs accredited, >70% of provincial and VL labs with at least > 3 star on SLMTA checklist
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate laboratory quality management systems to guarantee efficient laboratory process for accurate and reliable results	COP17	COP22	16 VL labs participating in DBS and plasma PT; achieving 100% pass rate; EID POC verification panel implemented in 80% of sites
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate laboratory quality management systems to guarantee efficient laboratory process for accurate and reliable results	COP17	COP22	80 % Gene Xpert sites participating in PT; Electronic data base for AFB/Xpert PT maintained in all provinces ; 95% pass rate for Xpert PT panels;
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Insufficient use of data for monitoring and evaluating program to inform responses required for epidemic control	COP17	COP22	70% of PEPFAR supported sites enrolled in PT program, 90% passed last PT panels; 70% of testing sites achieving at least level 3 on the RTCQII checklist (partially elegible for certification)
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Lack of appropriate lab data systems needed for scaling up quality VL, EID and/or TB testing	COP20	COP22	5 provinces monitoring HIV drug resistance

HHS/CDC	UNIVERSITY OF MARYLAND	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate laboratory quality management systems to guarantee efficient laboratory process for accurate and reliable results	COP17	COP22	70% of PEPFAR supported testing sites enrolled in PT program, 90% passed last PT panels; 70% of testing sites achieving at least level 3 on the RTCQII checklist (partially elegible for certification)
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Inadequate laboratory quality management systems to guarantee efficient laboratory process for accurate and reliable results	COP19	COP22	National strategy for the magement of chemical waste developed and submitted for approval; biosafety materials provided
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate laboratory quality management systems to guarantee efficient laboratory process for accurate and reliable results	COP16	COP21	16 VL labs participating in DBS and plasma PT; EID POC verification panel implemented in 60% of sites
HHS/HRSA	UNIVERSITY OF WASHINGTON	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	MR - Inefficient, non-client friendly service delivery models	COP19	COP22	5
HHS/CDC	INSTITUTO NACIONAL DE SAUDE	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Lack of adequate and well trained staff	COP19	COP21	5

USAID	Palladium International, LLC	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated		Inadequate public financial management system that prevents monitoring and tracking of HIV expenditures, disaggregated by program area	COP20	COP21	1
USAID	Palladium International, LLC	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated		Inadequate public financial management system that prevents monitoring and tracking of HIV expenditures, disaggregated by program area	COP20	COP22	1
USAID	Chemonics International, Inc.	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Poorly trained and insufficient human resources to achieve epidemic control	COP20	COP21	1
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Inadequate commodity data collection at the national/sub-national level and at the facility level	COP20	COP22	4 supply plans, 1 3HP & 1 6MDD training materials produced, 3 trainings completed
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Inadequate commodity data collection at the national/sub-national level and at the facility level	COP19	COP22	12

SRE Tool-E (Entry of Surveillance, Surveys, Research and Evaluation Activities)							
Funding Agency	**Activity Type**	**Project Title**	**Primary evaluation or study questions**	**Project Start COP Year**	**Project End COP Year**	**Current Stage of project (as of COP20)**	**How does this project advance COP priorities?**
HHS/CDC	Outcome	HIV prevention needs of migrants and mobile populations	Assess HIV prevention needs of migrants and mobile populations	COP20	COP20	Proposed in COP	Mozambique has a large population of migrant workers who travel between Mozambique and South Africa who are difficult to track and retain in care. This population-level evaluation could assist in developing strategies for engaging and retaining men, who currently lag in 12-month retention, and in understanding the size, HIV prevalence, and risk factors of this population.
HHS/CDC	Case surveillance	Case-based surveillance in Mozambique	Assess trends in HIV prevalence, sentinel events, mortality, and retention and assess quality and impact of programs	COP20	COP21	Proposed in COP	This project will advance COP priority to scale up case-based surveillance and assessment of epidemic control, beginning in a single province where EPTS harmonization and centralization has occurred.
HHS/CDC	Other	HDSS Polana Canico	Population-based health and demographic surveillance including assessment of HIV prevalence, mortality, and retention	COP20	COP21	Proposed in COP	This project will provide ongoing population-based surveillance data to monitor HIV prevalence, mortality, retention in care, health-related behaviors and demographic characteristics.
HHS/CDC	Population estimation	Key population mapping and size estimation	Map and estimate size of key populations in priority locations	COP20	COP20	Proposed in COP	This project will provide data to advance the COP priority of informing key populations prevention and treatment programs and is being done in conjunction with GF-funded BBS activities. This protocol will help provide needed KP mapping and population size estimation data to understand the KP HIV epidemic in Mozambique.

APPENDIX D– Minimum Program Requirements

The following table notes the status of each minimum program requirement.

Topic/Technical Area	Minimum Program Requirement	Status
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[23]	Test and start in place in all facilities. Estimated linkage reached 95% among women aged greater than 20 in Q1 but is lower in other age-sex groups. Need to continue to increase linkage and ensure immediate access to appropriate treatment for all age groups
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[24]	Circular released in November 2019 indicating DTG as preferred therapy for patients above 20 kg (both sexes). Transition of all eligible clients expected in FY20 Q3. This intervention is dependent on availability of adequate TLD stock. MISAU guidelines approved for full transition away from nevirapine-based regimens. As of January 2020, 58% of children < 20 kg were on lopinavir-based ARV regimens. Complete transition is dependent upon global commodity supply.
	3. Adoption and implementation of differentiated service delivery models,	65% of eligible clients on 3MDD 6MDD: In January 2020, 8 sites in Gaza began 6MDD.

[23] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

[24] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

	including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[25]	Readiness assessment completed in 46 sites in six provinces (3 sites in Maputo City, 12 in Sofala, 8 in Manica, 6 in Tete, 7 Niassa, 10 in Zambezia); further expansion of approved sites planned for April with nationwide expansion starting in Q3.
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[26]	Low TPT completion rate among those who initiated (29%). Plan in place for scale up to 100% initiation and completion. MISAU has approved 3-month drug distribution of INH, which needs to be more fully implemented. Cotrimoxazole being provided.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Diagnostic Network Optimization will be finalized in May. Mozambique does not currently have the laboratory capacity for 100% coverage of viral load testing. EID capacity is robust, with POC network continuing to outperform conventional EID PCR testing.
Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and	Scale up of community and facility index testing to all clinical IP sites in COP20; National Guidelines on self-testing released during FY20 Q1 and plans for immediate implementation of the STAR project

[25] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

[26] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

	assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[27]	(community distribution of self-test) and expansion of self- testing to all provinces; support demand creation and provide TA to expand self-testing to public -private pharmacies and facilitate linkage of positives. Anticipate Global Fund will support self-test kit purchase in COP20. IPV evaluation results used to inform national index testing model, including screening for IPV. Plans in COP19 to undertake certification of counselors and reinforce existing IPV monitoring systems. Policy update in FY20 Q1 to increase age of index testing to include adolescents with HIV+ parents; changed national screening tools to align with this policy change.
Prevention and OVC	7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[28]	Based on Zambezia PrEP evaluation, MISAU has concurred with COP20 scale up of PrEP for high-risk PBFW, high-risk adolescents aged 15 and older, sero-discordant couples, and key populations. Age of PrEP eligibility lowered from 18 to 15. Planned development of MISAU operational guidelines for large-scale implementation of PrEP.
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and	OVC_STAT achievement was above 100% of target and OVC_SERV for children under age 18 was 80% of target. Currently, 54% of all CLHIV on ART are also enrolled in OVC case management within

[27] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

[28] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

	treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	OVC program catchment areas, with plans to increase this coverage to 90% during COP20.
Policy & Public Health Systems Support	9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[29]	Mozambique does not have user fees for HIV and HIV-related services.
	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP	The team will continue conducting joint visits to assess and improve quality of care and monitor IP performance. The official MISAU QI program will continue to be supported in COP20 as documented in IP work plans.

[29] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

	work plans, Agency agreements, and national policy.[30]	
	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	In COP20 PEPFAR Mozambique will further expand stigma reduction, treatment literacy, and community-led monitoring activities, through direct funding to CNCS, PEPFAR Mozambique small grants, strategic marketing approach, and cooperative agreements with local organizations. Treatment literacy materials for the U=U campaign are in development and planned for launch in April 2020. National psychosocial support and HTC guidelines have recently been updated and disseminated and provide orientation to providers on HIV messaging to reduce stigma and encourage HIV treatment and prevention.
	12. Clear evidence of agency progress toward local, indigenous partner direct funding.	USAID and CDC both increased the proportion of total funding going to local partners in COP20. In COP20, PEPFAR Mozambique will fund $1.5 million in community monitoring work by small community-based organizations, creating capacity among indigenous partners to compete for future funding. There is also a commitment to increasing government ownership and management responsibility of programs and funds implemented by international partners with increasing funds going to government cooperative agreements in COP20.
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable	GRM supports the health system and, in addition, allocated $10 million to HIV commodities (ARVs and test kits) in COP19. Expenditure rate to be determined.

[30] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

	evidence of year after year increased resources expended.	
	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	There is an Electronic Patient Tracking System at 500 sites supported by clinical IPs that currently captures data on morbidity and mortality.
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Mozambique has birth registration and a unique identifier system which was recently implemented for children (400,000 children registered since December 2018). Registration is in effect in 163 conservatories and 307 hospitals with expansion ongoing. In COP20, a pilot project will be funded to facilitate registration of 1000 children in coordination with leading donors and the Ministry of Justice.

APPENDIX E – Acronym List

AE	Adverse Event
ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
AJUDA	Analyzing Joint Underperformance and Determining Assistance
ALHIV	Adults Living with HIV
ANC	Antenatal Clinic
APSS	Apoio Psicossocial
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
AYPLHIV	Adolescents and Youth Living with HIV
CCM	Country Coordinating Mechanism
CCS	Center for Collaboration in Health
CDC	Centers for Disease Control and Prevention
CETA	Common Elements Treatment Approach
CHWS	Community Health Workers
CLHIV	Children living with HIV
CMAM	Central de Medicamentos e Artigos Medicos
CNCS	Conselho Nacional de Combate ao HIV/SIDA /National Council to Combat AIDS
COP	Country Operation Plan
COREM	Conselho das Religiões de Moçambique
DHIS	District Health Information System
DOD	Department of Defense
DPS	Directorates of Provincial Health
DQA	Data Quality Assurance
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe
DSD	Direct Service Delivery
DTG	Dolutegravir
EID	Early Infant Diagnosis

EPTS	Electronic Patient Tracking Systems
EQA	External Quality Assessment
ER	Expenditure Reporting
FDC	Fundação para o Desenvolvimento da Comunidade
FP	Family Planning
FPM	Fund Portfolio Manager
FSW	Female Sex Workers
G2G	Government-to-Government
GAACs	Grupos de Apoio a Adesão Comunitária / Community ART Support Groups
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
GHSC-PSM	Global Health Supply Chain Procurement and Supply Chain Management
GIS	Geographic Information Systems
GNI	Gross National Income
GRM	Government of the Republic of Mozambique
HCN	Host Country Nationals
HCWs	Healthcare Workers
HEI	HIV Exposed Infants
HF	Health Facilities
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HRH	Human Resources for Health
HRSA	Health Resources and Services Administration
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
HVAB	Abstain/Be Faithful Budget Code
IBBS	Integrated Behavioral and Biological Survey
INS	National Institute of Health

INSIDA	Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação sobre o HIV e SIDS / AIDS Indicator Survey
IPs	Implementing Partners
KP KPIF	Key Population Key Population Investment Fund
LPV/r LEEP LIS LTFU	Lopinavir/ritonavir Loop Electrosurgical Excision Procedure Laboratory Information Systems Loss to Follow-Up
MAG M&E	Marketing Advisory Group Monitoring and Evaluation
M2M	Mães para Mães / Mothers to Mother
MCC MDD MDR-TB MER	Millennium Corporation Challenge Month Drug Distribution Multi-Drug-Resistant Tuberculosis Monitoring, Evaluation, and Reporting
MGCAS MINEF	Ministry of Gender, Children and Social Action Ministério da Economia e Finanças/Ministry of Finance
MISAU	Ministério da Saúde / Ministry of Health
MMS MSM	Multi-month Scripting Men Who Have Sex With Men
MTCT NASA NEC NGO NID NUIC NVP OGAC OTZ OU	Mother-to-child-Transmission National AIDS Spending Assessment New Embassy Compound Non-governmental Organization National Health Identification National Unique Identification Nevirapine Office of the Global AIDS Coordinator Operation Triple Zero Operating Unit

OVC	Orphans and Vulnerable Children
PBFW	Pregnant and Breastfeeding Women
PCR	Proper Molecular Biology
PEPFAR	President's Emergency Plan for AIDS Relief
PHIA	Population-based Impact Assessment
PICT	Provider-initiated counseling and testing
PLASOC	Plataforma da Sociedade Civil / Civil Society Platform for Health
PLHIV	People Living with HIV
PLL	Planning Level Letter
PLW	Pregnant and Lactating Women
PMTCT	Prevention of Mother-to-Child Transmission
POC	Point-Of-Care
PPP	Public-Private Partnership
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
RTK	Rapid Test Kit
SI	Strategic Information
SAAJ	Serviços Amigos dos Adolescentes e Jovens
SID	Sustainability Index Dashboard
SIMS	Site Improvement through Monitoring Systems
SNU	Sub-National Unit
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Technical Assistance
TAT	Turn-around Time
TLD	Tenofovir/Lamivudine/Dolutegravir
TPT	Tuberculosis Preventative Treatment
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	UNICEF United Nations International Children's Emergency Fund
USAID	United States Agency for International Development

USDH	United States Direct Hire
VACS	Violence Against Children Survey
VCT	Voluntary Counseling and Testing
VIA	Visual Inspection with Acetic Acid
VL	Viral Load
VMMC	Volunteer Medical Male Circumcision
VT	Vertical Transmission
WHO	World Health Organization